The VOLUNTARY HOSPITALS in GREAT BRITAIN

(EXCLUDING LONDON)

Fifth Annual Report for the Year 1923

By

F. N. KAY MENZIES

M.D., F.R.C.P.E., D.P.H.,

Director of Hospital Services, Joint Council of the Order of St. John and the British Red Cross Society

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With a Foreword by the

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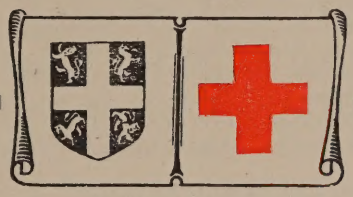

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Foreword.

By the Hon. Sir ARTHUR STANLEY, G.B.E., C.B., M.V.O.,

Chairman of the Joint Council of the Order of St. John and the British Red Cross Society.

The Fifth Annual Report of the Joint Council of the Order of St. John and the British Red Cross Society concerning the Provincial Hospitals of Great Britain is presented by Dr. F. N. Kay Menzies, M.D., F.R.C.P.E., D.P.H., who has succeeded the late Sir Napier Burnett as Director of the Hospitals and Medical Services Department. This Annual Report was instituted at the suggestion of Sir Napier Burnett as the first step in the co-ordination of the work of Voluntary Hospitals throughout the country. Those who have studied the Report in former years know how much it owed to the wisdom and experience of Sir Napier Burnett and can realise what his loss means to us. Dr. F. N. Kay Menzies is carrying on the issue of these Annual Reports on the foundations laid by Sir Napier Burnett, and I appeal to all Hospital Authorities to give him the assistance which they so generously extended to Sir Napier Burnett.

In my Introductory Note to the Report of the year 1921 I noticed that "in the year under review the majority of the Voluntary Hospitals were able to pay their way for the first time since the War." In 1922 I was able to point out that "the Ordinary Income on the Hospitals under review failed to meet the Ordinary Expenditure by only £74,978." In 1923, the year dealt with in the Report, an extraordinary advance has been made towards financial stability—the figures showing that in place of a deficiency of Ordinary Income of £74,978, there is actually a *surplus* of Ordinary Income over Ordinary Expenditure of no less than £213,694. This surely proves, if proof be needed, that the voluntary system is holding its own and that there is no immediate danger of Voluntary Hospitals being taken over by municipalities or by the State—with a consequent addition to the load of taxation which is already such a heavy burden upon the life of the Nation and its trade.

In his introduction to the Report, Dr. Menzies suggests that "some measure of uniformity should be observed by Hospitals great and small in the preparation of their Annual Reports." He is careful to point out that he does not mean by this suggestion that there should be a model Report to which all Hospitals should conform, but that certain essential data should be included in all Annual Reports and presented in common form. The great value of a uniform method of presenting accounts has been proved by King Edward's Fund, and there is no doubt that similar procedure in presenting Reports would lead to equally valuable results.

One very important step to which reference is made in Dr. Menzies's introduction and in the Report itself has been taken during the past year. The Voluntary Hospitals Commission has been requested by the Minister of Health "to enquire into, and to report to us upon, the extent of the additional Voluntary Hospital accommodation required in Great Britain, and the best means of providing and maintaining it." Those who have studied the question of Hospital accommodation during the difficult years which have elapsed since the War are now all agreed that the first requisite for a final settlement of the question is a comprehensive survey not only of the actual Hospital accommodation, but of the needs of the community. It is little use to make a general statement that Hospital beds are required for 2 per thousand of the population, and that if beds existing in Hospitals do not reach that figure there is a deficit of so many beds. The important thing is to know for what the beds are required, and how far, if at all, they fall short in any particular category. Once this is ascertained, it can very easily be seen whether rearrangement and co-ordination would not go far towards making good such deficiency as there may be.

I suggest, therefore—and in this I know that I shall have the support of the British Hospitals Association, as well as of the Joint Council—that the reference to the Voluntary Hospitals Commission shall be extended and that enquiry shall be made into the general need of Hospital accommodation, the special categories in which the need of further accommodation is felt and the possibility of supplying that accommodation in part, at all events, by better co-ordination and co-operation.

I hope and believe that this Report will be of service to those who are studying this and other Hospital questions, and I thank all Hospital authorities throughout the country for their kindness in furnishing the information upon which the Report is founded.

September, 1924.

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INTRODUCTION.

The Fifth Annual Report of the Joint Council concerning the Provincial Hospitals of Great Britain has been prepared under circumstances of considerable difficulty. In the first place, the unexpected and lamentable death, on Christmas Day, 1923, of Sir Napier Burnett, resulted in the irreparable loss to the Joint Council of the services of the author of the First Four Annual Reports. In connection with the work which he did for the Voluntary Hospitals many great and graceful tributes have justly been paid to his memory, and the compilation of the four Annual Reports which have preceded this issue will probably always rank as by no means the least of the great services which he rendered to the Voluntary Hospitals of this country. The Joint Council is to be congratulated upon their decision to carry on the issue of these Annual Reports, the foundations of which have been so well and truly laid by Sir Napier Burnett.

In the second place, owing to a number of circumstances, professional and personal, over which one has had no control, it was impossible for me to take up Sir Napier Burnett's work until after the Easter vacation of this year, and, even then, owing to a number of old standing engagements, extending throughout the whole summer, it was only possible for me to give a very limited amount of time to the work of the Joint Council, including as it did, amongst other things, the preparation of this Report. In these circumstances, I feel that I have been singularly fortunate in the possession of two such able, devoted and loyal colleagues as Mr. R. H. P. Orde and Mr. A. E. Ceadel, both of whom worked for a considerable time with the late Sir Napier Burnett in the production of previous Reports. It is absolutely true to say that without their invaluable assistance it would have been impossible, either for myself or anyone else, to produce this Report, and I am truly glad to have the opportunity of publicly stating this fact.

I also desire to express my wholehearted thanks to all those Hospital Secretaries and Superintendents throughout Great Britain who have been good enough, not only to send us their Annual Reports so soon as they were published, but also to supply us, where necessary, with certain supplementary information of considerable importance for the compilation of satisfactory statistical records.

In the Report for 1923, the late Sir Napier Burnett refers with some satisfaction to the fact that it was possible for the Survey to be published and issued at a date three months earlier than the Survey for the previous year. I wish it had been possible to make a similar remark this year. Altogether, apart from the personal difficulties referred to above, it would have been quite impossible to issue the Survey this year before the month of October, owing to the fact that many of the Hospital Reports were not available until August. I am largely in agreement with the statement made by the late Sir Napier Burnett in his last Annual Report, viz. :—" that the value of an Annual Report is enhanced in proportion as the date of its publication approximates the period of which it is a record," but, inasmuch as this Survey is based upon a careful and detailed analysis of the records of over 700 Hospital Reports, which appear at all sorts of dates between January and August of each year, it is obvious that we are mainly dependent, in so far as the date of publication is concerned, upon the earliest possible issue of the Reports of Voluntary Hospitals, great and small, throughout the length and breadth of Great Britain.

I.—THE OBJECT OF THE REPORT.

The object which the Joint Council have in mind in issuing this Report (or Survey) is the presentation in as full detail as possible of the position of the Provincial Voluntary Hospitals in Great Britain with reference to certain special features, which may be summarised thus :—

(*a*) The facilities available for treatment.
(*b*) The extent to which they are utilised by the community generally.
(*c*) The annual cost of maintaining these facilities, and
(*d*) The sources and extent of the financial resources by which they are maintained.

Those who attempt any such Survey as the Joint Council have in mind are, of course, compelled to rely, mainly at all events, upon the Reports which are issued to their Subscribers annually by the Voluntary Hospitals. Even a superficial glance at these Reports is sufficient to enable any person to realise that, quite naturally, they vary to a considerable extent in the amount of information which they contain and the manner in which this information is presented. It is, perhaps, not altogether surprising that some of the Reports omit altogether data which are absolutely essential for the purposes of a satisfactory Survey, while others prepare their accounts in a manner which, to say the least, renders the task of analysis and tabulation extremely difficult.

Again, it is worthy of note that some Hospital Reports supply exceedingly interesting and important information with regard to the social and industrial conditions obtaining in the area from which their patients are drawn. It is unnecessary at this point to emphasize the value of such information. Its real importance and value will be readily recognised when the time comes, as it most assuredly will in the near future, when some paramount authority will have to determine how far the facilities, whether Voluntary or Rate paid, at present available for the treatment of the sick in each and every county in Great Britain, are sufficient and satisfactory for the welfare of the community.

Two tables, relating to the Hospitals in England and Wales only, are given below as illustrations of the difficulties encountered in summarising Hospital Finances and Statistics.

METHOD OF PUBLISHING ACCOUNTS.

Hospitals.	Number of Hospitals using Revised Uniform System including a Balance Sheet.	Number of Hospitals using Revised Uniform System, but not publishing a Balance Sheet.	Number of Hospitals using other methods, but publishing a Balance Sheet.	Number of Hospitals using other methods and not publishing a Balance Sheet.
Group A	71=62%	29=25%	4= 3%	11=10%
Group B	58=31%	41=23%	27=15%	58=31%
Group C	50=15%	34=11%	35=11%	206=63%
Total	179=29%	104=17%	66=10%	275=44%

METHOD OF PUBLISHING BED ACCOMMODATION AND AVERAGE OCCUPATION.

Hospitals.	Hospitals giving both the available beds and the average number occupied.	Hospitals giving number of available beds but not the average occupation.	Hospitals giving the average number of beds occupied but not the total number available.	Hospitals giving neither available beds nor average occupation.
Group A	74=64%	2= 2%	37=32%	2= 2%
Group B	61=33%	19=10%	70=38%	34=19%
Group C	45=14%	63=19%	116=36%	101=31%
Total	180=29%	84=13%	223=36%	137=22%

The moral of these remarks would therefore appear to be that for such a Survey, as is here attempted, to be thoroughly reliable, some measure of uniformity should be observed by Hospitals, great and small, in the preparation of their Annual Reports. It is not suggested that they should entirely confine their Reports to a model schedule, but rather that for the common good, certain essential data should be included in all Annual Reports, and that these should be prepared and presented in common form.

II.—THE SCOPE OF THE REPORT.

This Report reviews 94·04 per cent. of the total Hospitals, containing 97·75 per cent. of the total available beds, leaving unreviewed 45 Hospitals containing 999 beds.*

	Total number of Hospitals reviewed in this Report.	Available Beds.	Total possible number of Hospitals.	Available Beds.
England and Wales	624	36,078	666	36,982
Scotland	86	7,326	89	7,421
	710	**43,404**	**755**	**44,403**

The number of Hospitals reviewed in the present and former Reports is shown in the following Tables :—

ENGLAND.

Number of Hospitals.			Available Beds.		
1919	... 600	... 89·82% of the total	33,514	...	93·60% of the total
1920	... 572	... 88·41% of the total	32,892	...	96·94% of the total
1921	... 581	... 90·64% of the total	33,356	...	95·54% of the total
1922	... 587	... 90·45% of the total	33,968	...	96·16% of the total
1923	... **624**	... **93·70%** of the total	**36,078**	...	**97·66%** of the total

SCOTLAND.

Number of Hospitals.			Available Beds.		
1920	... 78	... 82·98% of the total	6,606	...	94·63% of the total
1921	... 75	... 83·34% of the total	6,887	...	94·46% of the total
1922	... 79	... 86·52% of the total	7,075	...	96·53% of the total
1923	... **86**	... **96·63%** of the total	**7,326**	...	**98·72%** of the total

* In the London area there are 116 Hospitals, with 13,002 available beds. There are, therefore, in Great Britain, 871 Voluntary Hospitals, with 57,405 available beds.

III.—GENERAL SUMMARY OF THE FINANCES OF THE HOSPITALS REVIEWED IN 1923.

		England and Wales.			
Ordinary Income ...	£4,620,769		Ordinary Expenditure	£4,351,057	
Extraordinary Income and Receipts for Capital Purposes...	1,764,016		Extraordinary and Capital Expenditure ...	1,102,665	
		£6,384,785			£5,453,722
		Scotland.			
Ordinary Income ...	£765,547		Ordinary Expenditure	£821,565	
Extraordinary Income and Receipts for Capital Purposes...	538,740		Extraordinary and Capital Expenditure ...	105,828	
		1,304,287			927,393
Total Receipts		£7,689,072	Total Expenditure ...		£6,381,115

These figures deserve careful attention.

1. They give some indication of the magnitude of the Voluntary System. Of the Total Receipts, £7,051,248 were raised by voluntary effort, the remainder, £637,824 (8·29 per cent. of the total), being derived from Public Services, £550,918, and grants from the Voluntary Hospitals Commission, £86,906.
2. They show that the Ordinary Income exceeded the Ordinary Expenditure by £213,694.
3. They show that the Extraordinary Income and Receipts for Capital Purposes exceeded the Extraordinary and Capital Expenditure by £1,094,263.

In order to make the financial position of the Provincial Voluntary Hospitals still clearer, it is necessary to add some explanation of the terms "Ordinary" and "Extraordinary" as used in Hospital Finance. A very careful analysis of all the sources from which a Hospital draws its financial support brings out more and more clearly each year this important point, viz.: That to obtain an accurate idea of the ability of an individual Hospital and of the Hospitals as a whole to find money to meet their maintenance costs each year, it is necessary to take into account something more than those sums of money which in Hospital book-keeping nomenclature are classified as Ordinary Income. It is for those who are expert in accountancy to determine methods, form and nomenclature, and to make any modification in the usual practice to meet any special requirements of the Hospitals. But, when all is said and done, the real point in which the public are interested—and this is of paramount importance now that the ability of the Voluntary System to find money to meet the cost of its work has been questioned by the advocates of other systems—is the actual yearly cost of maintenance and the amount of money received each year available for meeting that cost. A large proportion of the Income classified as Extraordinary *is* available for this purpose, and includes sums which are received annually with such regularity that they can quite reasonably be counted upon. Indeed, if the available Extraordinary Income is taken into account, many Hospitals which show a deficit on Ordinary Income will be found to have an actual surplus for maintenance purposes, and many other Hospitals, even if they have an actual deficit on maintenance in any one year will, if a period of years be taken into account, also be found to have a surplus for maintenance purposes. The opponents of the Voluntary System are apt to regard the finances of the Hospitals only from the point of view of Ordinary Income and Ordinary Expenditure. The mistake is perhaps excusable,

for the term Extraordinary Income as used by the Hospitals is unusual. In this connection it is well worthy of note that if the figures of the Ordinary Income and Ordinary Expenditure of the Scottish Hospitals alone are studied, it might be inferred that, as a whole, they were unable to meet their running costs during 1923, whereas the reverse is the case, for there was available out of Extraordinary Income a sum which was more than sufficient to make good any deficiency of Ordinary Income, and which it would be quite reasonable to use for this purpose.

Any revision in the system of accounts that the altered circumstances of the times may make advisable will no doubt take into consideration the point which is here raised.

ORDINARY INCOME AND ORDINARY EXPENDITURE.

Using these terms in the sense in which they are understood in the Hospital world, and disregarding altogether sums available out of Extraordinary Income for maintenance purposes, we still find cause for great satisfaction in the figures for the year 1923. The following short summary shows at a glance the trend of Hospital finance in the Hospitals of Great Britain :—

Ordinary Income in 1921 *failed* to meet Ordinary Expenditure by **£**419,135.
Ordinary Income in 1922 *failed* to meet Ordinary Expenditure by **£**74,978.
Ordinary Income in **1923** *exceeded* Ordinary Expenditure by **£213,694.**

Even more striking are the figures of the percentage of Hospitals having a surplus of Ordinary Income :

In 1920 44 per cent. of Hospitals had a surplus of Ordinary Income.
In 1921 51 ,, ,, ,, ,, ,,
In 1922 57 ,, ,, ,, ,, ,,
In **1923 66** ,, ,, ,, ,, ,,

So far as Ordinary Income is concerned the figures of the Scottish Hospitals as distinct from those of the English are not quite so good. Attention, however, has already been drawn to the prominence which Extraordinary Income occupies in the financial position of the Scottish Hospitals so far as maintenance is concerned, and later in the Report it is also shown how largely legacies to Hospitals bulk in Scotland.

Percentage of Hospitals with a surplus of Ordinary Income :

	England.	*Scotland.*
1920	45 per cent.	42 per cent.
1921	53 per cent.	39 per cent.
1922	57 per cent.	53 per cent.
1923	**67** per cent.	**62** per cent.

INVESTED FUNDS AND THE INTEREST DERIVED THEREFROM.

In this connection the growth in the amount of Invested Funds and the Interest arising therefrom is of particular interest.

Hospitals in	Year.	Invested Funds.		Interest from Investments.	
		Total.	Per available bed.	Total.	Per available bed.
England and Wales ...	1919	£ 10,927,311	£ 326	£ 456,383	£ 13·61
	1923	**14,458,274**	**401**	**684,153**	**18·96**
Scotland	1920	2,900,122	422	136,687	20 69
	1923	**3,870,402**	**528**	**182,503**	**24·91**

IV.—PATIENTS TREATED DURING 1923.

Out of the 710 Hospitals the finances of which are reviewed in this Report, five Hospitals with 139 beds do not give details with regard to the number of patients treated during 1923. Consequently the following summary of work is not quite co-extensive with the summary of finance. The difference is, however, so small as to be practically negligible.

NUMBER OF PATIENTS TREATED.

	No. of Hosps. giving details.	No. of available beds.	Total No. of New In-Patients	Total No. of New Out-Patients.	Total No. of New Patients.
England and Wales.					
Medical School Hospitals ...	14	4,861	80,355	529,905	610,260
Non-Medical School Hospitals ...	606	31,092	381,479	1,439,289	1,820,768
Scotland.					
Medical School Hospitals ...	6	3,214	49,716	170,621	220,337
Non-Medical School Hospitals ...	79	4,098	55,378	154,563	209,941
	705	**43,265**	**566,928**	**2,294,378**	**2,861,306**

There is little difference between the English and Scottish Hospitals, either in the Medical or Non-Medical School groups, in the number of patients treated in each bed during the year. There is, however, a striking contrast in the matter of Out-patient work. For every In-patient treated in the English Medical School Hospitals, 6·5 Out-patients were treated. In the Scottish there were 3·4. This difference suggests that in the consideration of that most difficult problem—the Out-patient Department—the methods followed in Scotland might repay study.

It is difficult to say to what extent, if any, the volume of work has increased. The figures are affected by the larger number of Hospitals reviewed. It is, however, permissible to make some comparison of the cost of treatment in 1923 as compared with that of 1922.

	Total No. of Patients Treated.	Cost of Maintenance.
1922 ...	2,090,855 ...	£ 4,946,299
1923 ...	**2,861,306** ...	**5,162,393**

It is not possible to separate the cost of the In-patient from that of the Out-patient, and the actual cost of the former is, of course, very much greater than that of the latter. If, however, any comparison whatever is to be made, it can only be by (1) adding the two together and dividing the cost of maintenance by that total. If this is done, then the cost of a patient in 1923 works out at £1·8 against a cost of £2·4 in 1922. Or (2) by making no deduction for the cost of Out-patient work, and dividing the cost of maintenance by the number of In-patients. If this is done, the cost of the In-patient works out at £9·1 in 1923 and £9·9 in 1922.

V.—HOSPITAL ACCOUNTS.

Judging purely from my own personal experience, I know of no subject which appears to afford such a fruitful field for controversy as that of Hospital Accountancy. The best method of keeping Hospital accounts and the correct method of preparing an annual statement, so as to convey a true and faithful picture of the financial position of the Institution, seems to provide an unfailing source for differences of opinion. Upon this occasion, at all events, I do not propose to embark upon the expression of any opinion as to the merits or demerits of any one system as compared with another. The issue is not shirked because its importance is under-rated or on the ground that, on the whole, the present system (or lack of system), appears to satisfy the majority, at any rate, of the supporters of the Voluntary Hospitals. The truth is, of course, that the subject is one of great complexity and probably all experts will agree that the perfect system of Hospital Accountancy has yet to be found. In the meantime, I would strongly recommend all those who are charged with the responsibility of managing and controlling our Hospital finances to give careful study and thoughtful consideration to the very interesting and instructive contribution on this subject by Mr. Stone, which appears on page 89.

I only desire to add one further remark upon this subject, and it is this : That it is impossible nowadays for any person to argue any longer, as has been so frequently argued in the past, viz. :— that the Voluntary Hospital System is justified and should be maintained, because under this System a vast amount of sickness and suffering is cured and relieved, at little or no cost to the Public Purse. I think it should rather be argued that the strength of the Voluntary Hospital System and the real justification for its continuance, should be based upon the fact that this immense volume of work is carried out *more efficiently and more economically* than it can be by any other known method or system.

In making this statement I do not overlook the fact that efficiency and economy, in terms of pounds, shillings and pence, are by no means the only arguments in favour of the continuance of the Voluntary Hospital System, but I do think that the charitable Public is becoming, and quite rightly so, more and more discriminating in the selection of the voluntary institutions which it will support, and, therefore, any badly managed Voluntary Hospital which, like any badly managed business, is always more or less in debt, and periodically issues " S.O.S.'s " for financial support, lest its doors are to be closed or the number of its available beds reduced, is no friend to the Voluntary Hospital System. I am one of those who believe that the Public prefer to put their money into a Hospital run on the accepted principles of sound finance, rather than a Hospital which claims that to be in debt is a virtue, instead of a vice.

VI.—CO-OPERATION BETWEEN VOLUNTARY HOSPITALS AND PUBLIC AUTHORITIES.

In an address which I delivered in June last to the British Hospitals Association, I endeavoured to show that during quite recent years there had been a considerable growth in the responsibilities of Public Health Authorities in connection with the provision of treatment for various forms of disease, and I gave, as typical examples, such well-known instances as those of Tuberculosis, Venereal Disease, School Medical Treatment, Maternity and Child Welfare, etc. I also ventured to express the opinion that in the near future the Public Health Authorities were likely to be called upon to extend the provision of facilities for treatment in certain other directions, such as, (*a*) the provision of more beds for maternity cases, (*b*) the treatment of cases of Rheumatism, Chorea, Infantile Paralysis, etc. Reference was also made to the probable adoption in the near future of the Maclean Committee Report upon the Reform of the Poor Law, which, if translated into an Act of Parliament, would throw still further responsibility for the treatment of the sick upon the Public Health Authorities. Those who are interested in this question may like to read the full text of the address, which is printed in the Appendix.

I refer again here to the subject matter of the address, in order to draw attention to the great, and indeed urgent, need which appears to exist in this country for the provision of greater facilities for the treatment of certain well-known diseases, *e.g.*, Ophthalmia Neonatorum and Infantile Paralysis.

It is obviously impossible within the limits of this introductory statement to go in any detail into the reasons for the expression of this view. I feel confident, however, that all those who have read the Report of the Departmental Committee on the Causes and Prevention of Blindness (1922) will agree that it is almost a national scandal that Ophthalmia Neonatorum is still responsible for approximately 30 per cent. of all cases of total blindness in this country, not to mention a large number of cases of partial blindness. The position is made worse when it is borne in mind that we are dealing with an eminently curable disease, if prompt and efficient treatment is provided in the earliest stages. Generally speaking, throughout Great Britain there is inadequate provision for such treatment, with the inevitable result that many fresh cases of blindness (total or partial) arise each year which could and should be prevented. Blindness, especially when it is acquired in infancy, and still more when it is preventable, given the proper means for prevention and treatment, is a terrible tragedy, and one can hardly imagine any appeal more likely to be responded to by the charitable public, than one designed to provide adequate Hospital facilities for the treatment of this acute, highly dangerous and infectious disease.

Similarly, there occur in the early months and years of child life quite a considerable number of cases of a disease known as Poliomyelitis, the after effects of which are readily recognisable by the Lay Public in the form of Infantile Paralysis. Here again, there is ample evidence to warrant the statement that the Hospital accommodation available for the treatment of these cases is seriously inadequate. There is also ample evidence to show that such cases, if recognised at an early stage, and, thereafter, submitted to skilful, and, unfortunately in many instances, very prolonged treatment, will greatly benefit instead of sustaining irreparable injury for life.

I may be wrong in my view, but, at all events, judging by my own personal experience, I feel convinced that if the Voluntary Hospital System is unable adequately to cope with these diseases to such an extent as will prevent the occurrence of many of the disastrous and lifelong results which we see only too frequently nowadays, then public opinion ere long will insist, and rightly so, that adequate provision must be made by the Public Health Authorities.

The same remarks apply to a number of other diseases, which, though less acute, and not quite so tragic in their results, yet make a considerable draft upon the Health, Happiness and Welfare of the community.

Here again the moral I wish to draw is that the Boards of Management of our Voluntary Hospitals, throughout Great Britain, should endeavour to acquaint themselves with the particular needs of the area which they serve. To this end they should periodically confer with the Public Health Authority and the General Practitioners of the area wherein they are situated, in order to ascertain whether there are any directions in which they can usefully co-operate in the provision of facilities for the prevention and treatment of disease. In this connection, the experience of the Clergy and Ministry, the Social Welfare Workers, etc., are well worthy of consideration for a similar purpose.

I would also very strongly recommend that the General Practitioners of the area should be consulted with the object of ascertaining whether there are any means which can be taken by the Hospital Board to assist them in the diagnosis and treatment of their patients, *e.g.*, by placing at their disposal such Bacteriological, Radiological, Bio-chemical, and other methods of scientific investigation as can best be provided at a General or Special Hospital.

Mention has already been made of the fact that throughout the country generally, the Voluntary Hospitals and Public Authorities frequently co-operate for the purpose of providing facilities for the treatment of Tuberculosis, Venereal Disease, Maternity and Child Welfare, etc. It is, therefore, suggested that every opportunity should be taken, so far as possible, to extend this co-operation, because it is only by such a policy that the Voluntary Hospitals and the Public Authorities can do full justice to the claims of the community.

VII.—THE HOSPITAL DRUG BILL.

We have made an effort this year to arrive at an approximate estimate of the sum spent annually upon Drugs in the Provincial Hospitals of Great Britain, and we believe it to be certainly not less than £200,000.

Bearing in mind the huge figures of out-patient attendances, and the extraordinary faith in the efficacy of "a bottle of medicine," which still characterises the vast majority of the public, whether Hospital patients or not, the estimated amount, large though it is, will probably not surprise those who have any intimate knowledge of Hospital work. Even so, I submit that it is an item of Hospital Expenditure which is well worthy of careful consideration on the part of both the Hospital Board and the Honorary Medical Staff, for the following reasons, among others :—

(*a*) Careful perusal of Colonel Harrison's paper on page 97 should suffice to convince anyone, that in the case of one Hospital Department, at any rate, there is almost certainly, unless the matter has already received special attention, considerable scope for economy without the least sacrifice of efficiency.

(*b*) Several years ago, I had occasion to make a detailed enquiry into the costs of the Drug Bill in a number of Tuberculosis Dispensaries, both Voluntary and Municipal. In the course of this enquiry, it very soon became obvious that quite a considerable amount of unnecessary and extravagant expenditure was taking place upon Drugs, without any real benefit to the patients, and here again, it became possible to effect great economies without any sacrifice of efficiency, in fact, rather the contrary.

(*c*) Formerly many medical practitioners bought and dispensed their own drugs. In more recent years, the practice of dispensing by medical practitioners has greatly diminished and the vast majority of practitioners prescribe but do not dispense. The change of practice must have resulted in the practitioners generally becoming less and less acquainted with the cost of drugs in pounds, shillings and pence.

Without labouring the matter any further, therefore, I should like to suggest to Hospital Boards of Management and their Honorary Medical Staff that they should, where they have not already done so, appoint a Sub-Committee of their Medical Staff to investigate this question. Might I also add the following further suggestions ?

That the Sub-Committee should call for a number of prescriptions at random from the Wards and Out-patient Department.

That the Dispenser should then be asked to price out the cost of each of these prescriptions at so much per bottle of, say, eight or twelve ounces.

That, after pricing, the prescriptions should then be examined in detail by the Medical Staff concerned, with a view particularly to determining whether there are any ingredients in each prescription which might be either omitted altogether, or replaced by other ingredients of equal therapeutic value, but costing less.

I believe that the result of such an Enquiry would in many cases provide some rather astonishing food for reflection on the part of both the members of the Honorary Medical Staff and the Lay Committee.

VIII.—MISCELLANEOUS.

Owing to the restrictions imposed by the limitations of space, it is not possible in this issue to make more than a passing reference to a number of matters of considerable importance. Amongst these may be mentioned :—

(*a*) *National Health Insurance, Unemployment Insurance and Old Age Pensions.*—These are subjects which are more or less intimately related. Without making the slightest claim to any prophetic instinct, it seems to me to be fairly certain that these three questions are going to play a

very prominent part in the Political Programme during the next few years, no matter which Party is in power or trying to get into power. Just as these three subjects are intimately related to each other, so are they all three related in one way and another to the Poor Law, and any comprehensive effort to deal with Poor Law or Insurance cannot be successfully undertaken without considering all these questions together. Therefore, all those who are interested in the welfare of our Voluntary Hospitals will be well advised to keep a watchful eye upon any proposals which may be put forward in connection w th these great Social Services, because such proposals may have very far-reaching effects upon "Hospital Contributory Schemes."

The Fourth Annual Report contained two papers by the late Sir Napier Burnett on "Contributory Schemes," and in this issue we welcome a "contribution" by Sir Francis Colchester-Wemyss on the same subject, which will, I feel sure, be read with great interest by the Members of Boards of Management.

(*b*) *Beds for paying patients.*—The provision of Hospital beds for patients—particularly of the Middle Classes, who are able to pay at least the full cost of maintenance, as well as their own medical fees, is an attractive subject to dilate upon. But at the present moment we have not got at our disposal a good deal of information which is essential for the purposes of a balanced statement. While, therefore, we are convinced of the desirability of such provision, we have decided to postpone until our next Annual Report the full treatment which such an important subject deserves. It would be a very great advantage in connection with the compilation of this Report if those Voluntary Hospitals which already make some provision for paying patients would include in their Annual Reports particulars with regard to the number of beds, patients treated and the scale of charges, etc.

(*c*) *The Voluntary Hospitals Commission* is now engaged in dealing with a reference from the Minister of Health, which is in the following terms :—"The Voluntary Hospitals Commission are requested to enquire into, and to report to us upon, the extent of the additional Voluntary Hospital accommodation required in Great Britain, and the best means of providing and maintaining it."

It is obvious that the results of this Enquiry and the report submitted thereon to the Minister will be awaited with considerable interest by all those who are engaged in Voluntary Hospital work. In the meantime, so far as this Report is concerned, we must reluctantly regard the Reference and all it implies as sub judice.

F. N. Kyllmanzies.

September, 1924

SECTION 1.

VOLUME OF WORK DONE.

Throughout this Report the Hospitals reviewed are grouped under the headings :—

Group A. Hospitals having **100** or more beds.

Group B. Hospitals having **30** to **99** beds.

Group C. Hospitals having less than **30** beds.

Tables are also given of Hospitals having Medical Schools attached, and of the General and Special Hospitals in each Group.

In the 620 Hospitals giving details 461,834 new In-patients and 1,969,194 new Out-patients received treatment during 1923. The main pressure of this work falls upon the Group A Hospitals, in which the percentage of occupation continues to rise. The percentage of occupation it is true has also risen in the Group C Hospitals. This, however, is a matter of less moment, as there is still a large margin of beds, almost 30 per cent., constantly vacant. That the number of beds upon which a Hospital bases its normal staff and establishment is not keeping pace with the work it actually undertakes, is brought out in the Report of one of the large General Hospitals, in which it is stated :—

> "Turning to the figures for 1923 it will be seen that they have surpassed all previous records, the daily average number of beds occupied during the year being 537, which is equal to three beds in excess of the normal number available. The highest number of beds occupied on any one day was 591."

More than a third of the large Hospitals with Medical Schools attached had an occupation exceeding 90 per cent. In other words, if the available accommodation were utilised only to the extent of its true capacity—and in a large General Hospital with all its sub-division of male, female, children's

TABLE 1.

NUMBER OF IN-PATIENTS AND OUT-PATIENTS TREATED AND PERCENTAGE OF AVAILABLE BEDS OCCUPIED.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Percentage of available beds occupied daily.	No. of New In-patients.	No. of New Out-patients
Group A	1920	106	20,056	81·92%	248,426	1,191,016
	1921	108	20,525	80·67%	257,638	1,269,118
	1922	108	20,730	82·17%	260,066	1,273,792
	1923	**115**	**22,071**	**82·75%**	**295,303**	**1,426,178**
Group B	1920	160	8,202	76·78%	97,619	388,707
	1921	160	8,234	74·57%	93,710	353,315
	1922	159	8,180	73·01%	95,575	342,957
	1923	**183**	**9,116**	**72·68%**	**112,758**	**424,108**
Group C	1920	289	4,122	69·43%	50,363	130,851
	1921	301	4,359	61·79%	50,643	144,720
	1922	304	4,446	59·23%	47,395	110,589
	1923	**322**	**4,766**	**62·79%**	**53,773**	**118,908**
Total	1920	555=97% (*a*)	32,380=98% (*b*)	—	396,408	1,710,574
	1921	569=98% (*a*)	33,118=99% (*b*)	—	401,991	1,767,153
	1922	571=97% (*a*)	33,356=98% (*b*)	—	403,036	1,727,338
	1923	**620=99% (a)**	**35,953**=99% (*b*)	—	**461,834**	**1,969,194**

(*a*) Percentage of Hospitals reviewed.
(*b*) Percentage of beds in Hospitals reviewed.

and special beds, an occupation of 80 to 85 per cent. indicates high pressure—the waiting lists would be very much greater than they are. The difficulty is, of course, a financial one, and the answer of the Hospitals would naturally be: "Support us more generously and we will provide the accommodation required." On the other hand, it is possible that a somewhat wider view of the needs of an area than that of the individual Hospital, might be the means of—to use a mechanical illustration—adjusting power to load. At present, load is allowed to make itself evident only by straining power to the breaking point.

Table 2 gives figures of In-patients and Out-patients treated in General and Special Hospitals separately. The proportionately large number of Out-patients treated in the Special Hospitals, especially in the C Group, is noticeable. In some of these the Out-patient department is the main feature and bulks largely in the figure of work done. The number of In-patients to beds in the smaller Hospitals, both General and Special, includes, of course, a large proportion of short stay patients.

TABLE 2.

NUMBER OF PATIENTS TREATED IN GENERAL AND SPECIAL HOSPITALS DURING 1923 SHOWN SEPARATELY.

Hospitals.	No. of Hospitals giving details.	No. of available beds.	No. of New In-Patients.	No. of New Out-Patients.
General Hospitals—				
Group A	98	18,836	264,015	1,268,485
Group B	127	6,330	74,277	220,251
Group C	292	4,199	45,282	55,627
Total of General Hospitals...	**517**	**29,365**	**383,574**	**1,544,363**
Special Hospitals—				
Group A	17	3,235	31,288	157,693
Group B	56	2,786	38,481	203,857
Group C	30	567	8,491	63,281
Total of Special Hospitals ...	**103**	**6,588**	**78,260**	**424,831**

TABLE 3.

NUMBER OF SURGICAL OPERATIONS (under general anæsthetic).

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds, and percentage of total reviewed.	No. of operations.
Group A	1921	97	18,481=90%	192,052
	1922	101	19,503=93%	215,935
	1923	**105**	**19,872=90%**	**238,594**
Group B	1921	135	7,129=85%	72,088
	1922	135	7,118=84%	76,974
	1923	**163**	**8,327=90%**	**93,703**
Group C	1921	201	3,067=68%	32,675
	1922	194	3,006=66%	28,939
	1923	**259**	**3,934=82%**	**35,608**
Total	1921	433=74·53%*	28,677=85·97%	296,815
	1922	430=73·25%*	29,627=87·22%	321,848
	1923	**527=84·46%***	**32,133=89·07%**	**367,905**

* Percentage of Hospitals reviewed.

TABLE 4.

X-RAY DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed.	* Total No. of patients treated in those Hospitals.	No. of Radiographs.	No. of Screen Exams.	No. of Treatments.
Group A	1922	54=49·54%	786,861	100,630	26,495	50,745
	1923	**59=51·30%**	**1,004,206**	**143,539**	**45,889**	**67,068**
Group B	1922	29=17·68%	63,679	9,889	4,867	11,488
	1923	**43=23·37%**	**132,379**	**15,229**	**4,963**	**8,449**

* These patient figures (including both in- and out-patients) do not refer to the work in the department.

TABLE 5.

ELECTRICAL-THERAPEUTIC DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed.	*Total patients treated at those Hospitals.	No. of Treatments given.
Group A	1922	33=30·27%	465,986	311,365
	1923	**31=26·96%**	**396,710**	**216,889**
Group B	1922	14= 8·54%	36,870	55,175
	1923	**17= 9·24%**	**59,624**	**56,908**

* These patient figures (including both in- and out-patients) do not refer to the work in the department.

TABLE 6.

MASSAGE DEPARTMENT.

Hospitals.	Year.	No. of Hospitals giving details, and percentage of total reviewed.	*Total patients treated at those Hospitals.	No. of Treatments given.
Group A	1922	46=42·20%	697,728	546,606
	1923	**39=33·91%**	**650,657**	**479,496**
Group B	1922	17=10·37%	44,627	100,419
	1923	**23=12·50%**	**73,200**	**68,453**

*These patient figures (including both in- and out-patients) do not refer to the work in the department.

TABLE 7.

SURVEY OF THE WORK DONE IN THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

1	2	3	4	5	6	7	8	9	10
Hospital	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of new In-patients.	No. of In-patients per occupied bed.	Average length of stay per In-patient (days).	No. of new Out-patients.	No. of Surgical Operations
A	1920	324	267·62	82·60	4,198	15·7	23·25	27,110	2,094
	1921	324	260·00	80·25	4,153	16·0	22·85	26,733	3,830
	1922	324	273·59	84·44	4,477	16·4	22·36	26,821	4,233
	1923	**324**	**280·56**	**86·59**	**4,780**	**17·0**	**21·41**	**29,116**	**4,056**
B	1920	218	174·33	79·96	2,148	12·3	29·58	16,854	—
	1921	218	172·18	78·98	2,355	13·6	26·60	15,822	1,565
	1922	218	181·85	83·41	2,428	13·4	27·49	16,638	1,758
	1923	**220**	**189·50**	**86·14**	**2,488**	**13·1**	**27·98**	**18,966**	**2,173**
C	1920	400	335·00	83·75	6,930	20·6	17·60	42,376	5,923
	1921	370	317·00	85·68	5,818	18·3	19·70	40,907	4,941
	1922	370	297·00	80·27	5,773	19·4	19·00	42,041	5,421
	1923	**370**	**314·00**	**84·86**	**6,153**	**19·6**	**18·62**	**47,696**	**6,317**
D	1920	224	182·10	81·29	3,215	17·6	21·80	20,868	3,147
	1921	224	178·80	79·82	3,229	18·0	20·10	19,128	—
	1922	224	180·80	80·71	3,602	19·9	18·30	20,224	3,652
	1923	**224**	**181·70**	**81·12**	**3,437**	**18·9**	**19·20**	**23,547**	**3,751**
E	1920	363	310·00	85·40	5,302	17·1	14·50	35,482	3,576
	1921	381	335·00	87·93	5,303	15·8	—	34,804	4,089
	1922	381	341·00	89·50	5,487	16·1	—	34,367	4,068
	1923	**363**	**351·00**	**96·69**	**5,445**	**15·5**	**25·00**	**38,859**	**2,609**
F	1920	236	221·00	93·64	3,499	15·8	23·14	38,379	3,880
	1921	236	204·00	86·44	3,164	15·5	22·23	31,703	3,658
	1923	236	210·00	88·98	3,115	14·8	23·25	32,721	3,323
	1923	**316**	**234·00**	**74·05**	**3,683**	**15·7**	**23·52**	**47,926**	**3,836**
G	1920	350	245·00	70·00	4,551	18·5	19·60	60,027	—
	1921	297	269·00	90·57	5,368	19·9	18·50	51,888	—
	1922	350	275·60	78·74	5,403	19·6	19·70	44,899	2,436
	1923	**350**	**287·70**	**82·20**	**6,042**	**21·0**	**17·30**	**55,506**	**2,604**
H	1920	268	230·25	85·91	3,784	16·4	22·14	27,049	—
	1921	268	232·29	86·68	3,843	16·5	22·00	24,688	2,421
	1922	268	239·15	89·24	3,966	16·6	22·01	22,157	2,108
	1923	**268**	**241·88**	**90·25**	**4,212**	**17·4**	**20·94**	**25,088**	**3,422**
I	1920	622	543·90	87·44	11,550	21·2	18·30	44,071	8,898
	1921	671	529·00	78·84	11,252	21·3	17·16	47,164	8,259
	1922	614	524·46	85·42	11,044	21·1	17·33	46,623	8,049
	1923	**614**	**541·00**	**88·11**	**10,696**	**19·8**	**17·62**	**46,596**	**8,698**
J	1920	532	390·00	73·31	9,044	23·2	14·50	44,128	9,307
	1921	532	429·00	80·64	9,242	21·5	16·00	42,771	8,231
	1922	546	445·00	81·50	9,785	22·0	15·90	41,857	9,470
	1923	**542**	**461·00**	**85·06**	**10,778**	**23·4**	**15·05**	**47,536**	**10,552**
K	1920	550	508·00	92·36	10,332	20·3	17·90	84,125	9,856
	1921	534	512·60	95·99	10,962	21·4	17·00	92,724	11,079
	1922	534	525·40	98·39	11,411	21·7	16·80	93,406	11,755
	1923	**534**	**537·40**	**100·64**	**12,159**	**22·6**	**16·10**	**105,426**	**12,256**
L	1920	190	176·00	92·63	2,074	11·8	31·00	7,664	1,805
	1921	232	174·00	75·00	2,418	13·9	25·82	8,782	2,454
	1922	210	176·00	83·81	2,984	17·0	22·00	7,733	2,594
	1923	**205**	**169·00**	**82·44**	**3,092**	**18·3**	**20·40**	**9,971**	**2,178**
M ...	1920	190	142·00	74·74	2,339	16·4	22·16	9,502	2,590
	1921	190	163·00	85·79	2,326	14·3	25·81	8,982	2,482
	1922	190	168·00	88·42	2,231	13·3	27·46	8,987	2,376
	1923	**190**	**179·00**	**94·21**	**2,374**	**13·3**	**27·77**	**10,166**	**2,596**
*N	**1923**	**341**	**318·60**	**93·43**	**5,016**	**15·7**	**24·33**	**23,476**	**4,619**
Totals ...	1920	4,467	3,725·20	83·26	68,966	18·5	—	457,635	—
	1921	4,477	3,775·87	84·34	69,433	18·4	—	446,096	—
	1922	4,465	3,837·85	85·95	71,706	18·7	—	438,474	—
	1923	**4,861**	**4,286·34**	**88·18**	**80,355**	**18·7**	—	**529,905**	—

* Recognised as a Medical School during 1923.

SECTION 2.

TOTAL RECEIPTS AND TOTAL EXPENDITURE.

The excess of Total Receipts over Total Expenditure for the year 1923, amounting to the large sum of £931,063 shown in Table 8, is remarkable enough as an isolated fact. It becomes more significant when considered in conjunction with the figures for the three preceding years. The Total Receipts of the English and Welsh Hospitals during the four-year period 1920 to 1923 inclusive, have exceeded the Total Expenditure by no less a sum than £2,815,151.

It is true that, as Table 10 shows, in approximately one-third of the 624 Hospitals (in each group the proportion is about the same) Total Receipts failed to meet Total Expenditure ; but this fact becomes less alarming when illuminated by the figures of preceding years. For this purpose the figures for the years 1920 to 1923 (inclusive) of Total Receipts and Total Expenditure of the 34 Hospitals in the group of large or A Hospitals, which show a combined deficit for the year 1923 of £217,332, have been analysed. This analysis disposes of the conclusion which might be hastily drawn that one-third of the Voluntary Hospitals are unable to keep their heads above water. Owing to the fact that the raising of money for building and other capital purposes does not proceed *pari passu* with the spending of it, good and bad years from a surplus and deficit point of view, in Total as distinguished from Ordinary Income and Expenditure, are bound to come to each Hospital in turn. It is not until deficit follows deficit with unbroken regularity that it is necessary to look elsewhere for a cause. Table 11 shows the true position of these 34 deficit Hospitals of the year 1923. The figures of the Hospitals with deficits in Groups B and C have not been analysed. It is not, however, unreasonable to assume that they do not differ in this respect from those in Group A.

TABLE 8.

TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	107	£4,060,073	£3,408,452	£651,621
	1921	108	3,455,612	3,454,432	1,180
	1922	109	3,491,545	3,127,931	363,614
	1923	**115**	**4,211,350**	**3,575,704**	**635,646**
Group B	1920	164	1,336,558	1,125,998	210,560
	1921	164	1,309,627	1,185,713	123,914
	1922	164	1,250,681	1,061,348	189,333
	1923	**184**	**1,437,548**	**1,246,068**	**191,480**
Group C	1920	301	730,245	554,985	175,260
	1921	309	675,858	614,241	61,617
	1922	314	753,712	646,723	106,989
	1923	**325**	**735,887**	**631,950**	**103,937**
Total	1920	572	£6,126,876	£5,089,435	£1,037,441
	1921	581	5,441,097	5,254,386	186,711
	1922	587	5,495,938	4,836,002	659,936
	1923	**624**	**6,384,785**	**5,453,722**	**931,063**

TABLE 9.

HOSPITALS HAVING AN **EXCESS OF TOTAL RECEIPTS** OVER TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	71 (66%)	£3,035,856	£2,228,212	£807,644
	1921	53 (49%)	1,817,081	1,482,852	334,229
	1922	77 (71%)	2,609,243	2,101,929	507,314
	1923	**81 (70%)**	**3,347,221**	**2,494,243**	**852,978**
Group B	1920	105 (64%)	989,091	721,487	267,604
	1921	96 (59%)	875,717	627,541	248,176
	1922	124 (76%)	1,024,741	786,663	238,078
	1923	**126 (68%)**	**1,062,048**	**762,146**	**299,902**
Group C	1920	203 (67%)	544,728	335,796	208,932
	1921	206 (67%)	477,788	349,245	128,543
	1922	222 (71%)	601,104	440,734	160,370
	1923	**239 (74%)**	**570,762**	**414,779**	**155,983**
Total	1920	379 (66%)	£4,569,675	£3,285,495	£1,284,180
	1921	355 (61%)	3,170,586	2,459,638	710,948
	1922	423 (72%)	4,235,088	3,329,326	905,762
	1923	**446 (71%)**	**4,980,031**	**3,671,168**	**1,308,863**

TABLE 10.

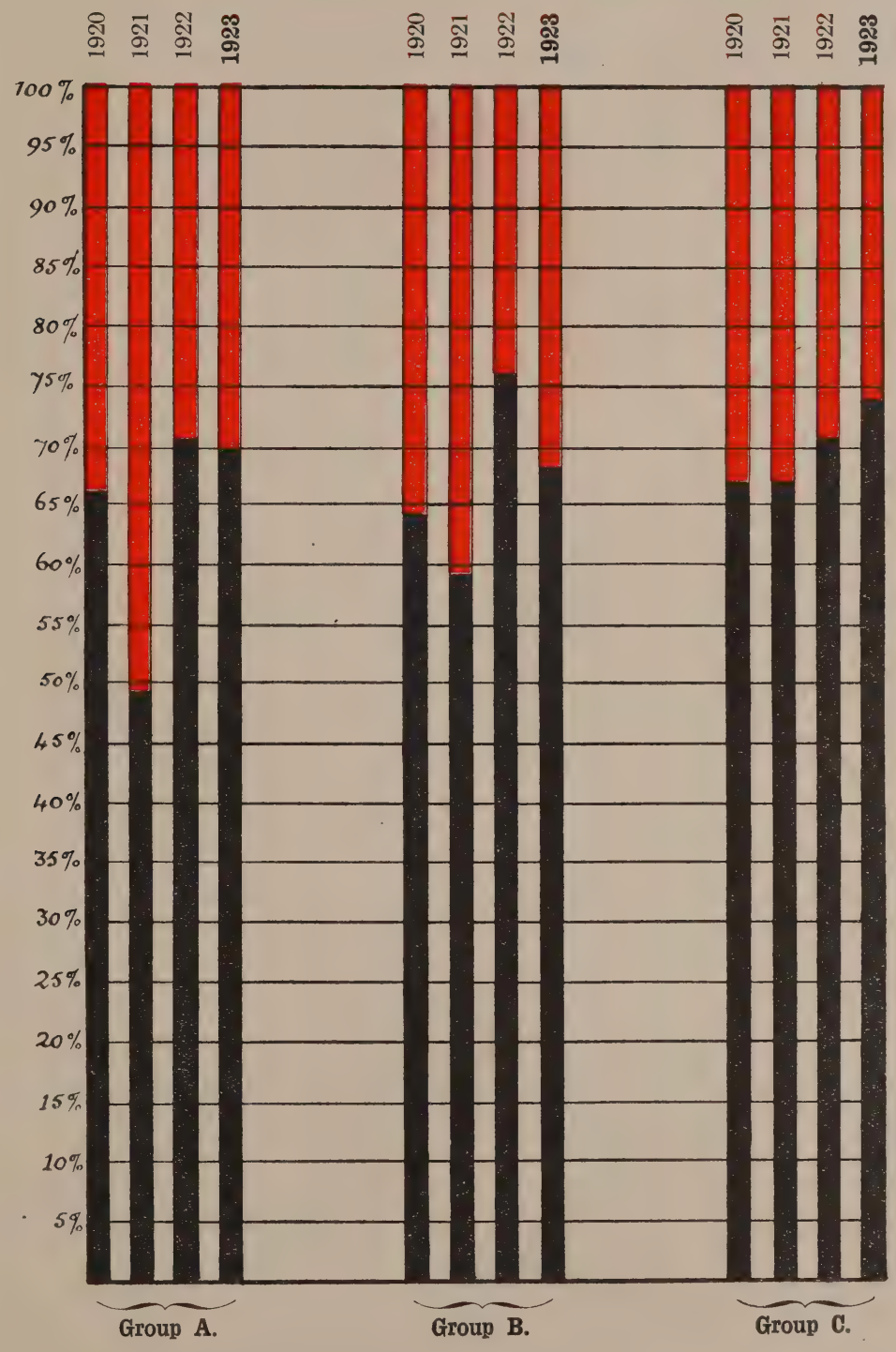
HOSPITALS HAVING AN **EXCESS OF TOTAL EXPENDITURE** OVER TOTAL RECEIPTS.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Deficit.
Group A....	1920	36 (34%)	£1,024,217	£1,180,240	£156,023
	1921	55 (51%)	1,638,531	1,971,580	333,049
	1922	32 (29%)	882,302	1,026,002	143,700
	1923	**34 (30%)**	**864,129**	**1,081,461**	**217,332**
Group B	1920	59 (36%)	347,467	404,511	57,044
	1921	68 (41%)	433,910	558,172	124,262
	1922	40 (24%)	225,940	274,685	48,745
	1923	**58 (32%)**	**375,500**	**483,922**	**108,422**
Group C	1920	98 (33%)	185,517	219,189	33,672
	1921	103 (33%)	198,070	264,996	66,926
	1922	92 (29%)	152,608	205,989	53,381
	1923	**86 (26%)**	**165,125**	**217,171**	**52,046**
Total	1920	193 (34%)	£1,557,201	£1,803,940	£246,739
	1921	226 (39%)	2,270,511	2,794,748	524,237
	1922	164 (28%)	1,260,850	1,506,676	245,826
	1923	**178 (29%)**	**1,404,754**	**1,782,554**	**377,800**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—

TOTAL RECEIPTS ... ... Shown in Black.

TOTAL EXPENDITURE ... Shown in Red.



Illustrating Tables 9 *and* 10.

TABLE 11.

ANALYSIS OF THE TOTAL RECEIPTS AND TOTAL EXPENDITURE FOR THE FOUR YEARS 1920 TO 1923 INCLUSIVE OF THE 34 GROUP A HOSPITALS IN TABLE 10 WHOSE TOTAL RECEIPTS FAILED TO MEET TOTAL EXPENDITURE DURING 1923.

Hospitals with a *surplus of Total Receipts* during the years 1920 to 1923 inclusive.		Hospitals with an *excess of Total Expenditure* during the years 1920 to 1923 inclusive.	
Hospital.	Surplus.	Hospital.	Deficit.
A	£24,464	T*	£3,446
B	24,009	U	21,921
C	36,464	V*	3,511
D	1,985	W*	13,722
E	1,769	X*	6,828
F	19,508	Y*	27,847
G	17,504	Z*	20,785
H	787	AA*	174
I	58,174	BB*	2,283
J	15,360	CC*	2,255
K	12,507	DD*	18,745
L	6,912	EE*	10,656
M	816	FF*	1,816
N	32,949	GG*	12,984
O	6,785		
P	35,928		
Q	9,988		
R	20,434		
S	1,806		
Total	£328,149	Total	£146,973
or an average of £17,271 per Hospital.		or an average of £10,498 per Hospital.	

* At these Hospitals extensive building schemes have been carried out during the period.

Note.—One of the 34 Hospitals with a deficit is new and the figures are available only for the year 1923.

TABLE 12.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available beds.	Total Receipts.	Total Expenditure.	Surplus.
General Hospitals—					
Group A	98	18,836	£3,708,636	£3,138,060	£570,576
Group B	128	6,420	940,225	881,183	59,042
Group C	295	4,234	635,380	548,633	86,747
Total	521	29,490	£5,284,241	£4,567,876	£716,365
Special Hospitals—					
Group A	17	3,235	£502,714	£437,644	£65,070
Group B	56	2,786	497,323	364,885	132,438
Group C	30	567	100,507	83,317	17,190
Total	103	6,588	£1,100,544	£885,846	£214,698

SECTION 3.

ORDINARY INCOME AND ORDINARY EXPENDITURE.

Tables 13, 14, 15 and 16 provide a striking testimony to the vitality of the voluntary system.

Some, of course, of the increase in the figure of the total Ordinary Income of the year 1923 over that of 1922, viz., £445,358, is due to the fact that a larger number of Hospitals—37—is included in the review. At the same time, it is worthy of note that this increase is more than three times as great as the increase in the figure of the total Ordinary Expenditure.

In each group *as a whole* progress since 1920 has been uninterrupted. In Group A a deficit of £448,061 has been converted into a surplus of £141,745.

In Group B a deficit of £37,782 has been converted into a surplus of £85,721.

In Group C a surplus of £22,887 has been raised to a surplus of £42,246.

The general improvement shown in Table 13 is naturally reflected in Tables 14 and 15, and it is noteworthy that three times as many of the large Hospitals paid their way in 1923 as in the year 1920. Moreover, the rate of progress appears to be an increasing one.

This rate of progress is most clearly shown in Table 16, in which the disturbances caused by a variation in the number of Hospitals reviewed, as well as by increases in the size of a certain proportion of those previously included, is eliminated by putting the figures on an available bed basis. For the first time in the past four years, each group shows an excess of Ordinary Income over Ordinary Expenditure. The conversion by the Group A Hospitals of a deficit of £6 per available bed to a surplus of £6 in one year is eminently satisfactory.

There are two factors which have a considerable bearing upon the figures showing Ordinary Income and Ordinary Expenditure which must not be overlooked. According to the Revised Uniform System of Hospital Accounts, "Contributions specifically made to reduce accumulated deficiencies of income must not be excluded from the Income and Expenditure Account; but there is no objection to their being entered under Extraordinary Income instead of Ordinary Income, if it is desired to do so." Again, free legacies are considered as Extraordinary Income, although they are available for maintenance purposes and differ in no essential respect from a donation given during the lifetime of the donor. From this it follows that Ordinary Income, as understood in the Hospital world, and as entered in these Tables, does *not* represent all the money available for maintenance purposes. If the Tables were prepared on a basis of money available for maintenance purposes, and the cost of such maintenance, there would be fewer Hospitals showing a deficit on the year's working.

Table 17, which contrasts Ordinary Income and Ordinary Expenditure in the General and Special Hospitals in each Group, must be read in conjunction with the following :—

No. of Out-Patients per Available Bed.

	General.	*Special*
Group A	67	49
Group B	34	73
Group C	13	111

As the bed basis carries the cost of the out-patient department, which has, of course, no necessary connection with the bed, there being many Hospitals with no out-patient departments at all, the very much greater proportion of out-patients to beds in the Special Hospitals in the B and C Groups, naturally raises the figure of their expenditure. It is often said that Special Hospitals are very much more expensive to run than General. Possibly this is so, but before attempting the comparison it is necessary to possess more detailed information than is at present available. Bed for bed, the Special Hospitals are doing over eight times as much out-patient work as the General Hospitals in the C Group and more than twice as much as the General in the B Group.

The relative cost of a bed in the General Hospitals in each of the Groups is also influenced by this same factor of the out-patient department, as can be readily understood from the figures of "out-patients to beds," viz., 67, 34 and 13 respectively.

On the whole, the financial position of the Special Hospitals appears to be rather better than that of the General and they have comparatively a larger surplus of Ordinary Income over Ordinary Expenditure.

Table 18 shows the financial position of the Teaching Hospitals in the matter of Ordinary Income and Ordinary Expenditure individually. In this Table the basis of the Occupied Bed is used. In 1923 five of these Hospitals had a surplus of Ordinary Income over Ordinary Expenditure. In 1922 there was only one. The marked tendency towards improvement in their financial position continuous since 1920 is highly satisfactory.

Table 19 shows the very considerable improvement that has taken place in the Income of the Teaching Hospitals: £22 per available bed over the four-year period and £15 between the years 1922 and 1923. There is still a deficit of £9 per available bed; four years ago this deficit was £49. The non-Teaching Hospitals have also shared in the upward tendency, though not to quite so great an extent. They have also been able to reduce their expenditure by £5 per available bed, so that now their Ordinary Income more than meets their Ordinary Expenditure by the handsome margin of £11 per available bed.

TABLE 13.

ORDINARY INCOME AND EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.	Surplus.
Group A ...	1920	107	£2,510,968	£2,959,029	£448,061	—
	1921	108	2,599,892	2,956,763	356,871	—
	1922	109	2,684,704	2,799,135	114,431	—
	1923	**115**	**3,008,120**	**2,866,375**	—	**£141,745**
Group B ...	1920	164	967,826	1,005,608	37,782	—
	1921	164	986,302	1,002,402	16,100	—
	1922	164	992,829	942,003	—	50,826
	1923	**184**	**1,085,000**	**999,279**	—	**85,721**
Group C ...	1920	301	494,149	471,262	—	22,887
	1921	309	507,583	484,541	—	23,042
	1922	314	497,878	462,358	—	35,520
	1923	**325**	**527,649**	**485,403**	—	**42,246**
Total	1920	572	£3,972,943	£4,435,899	£462,956	—
	1921	581	4,093,777	4,443,706	349,929	—
	1922	587	4,175,411	4,203,496	28,085	—
	1923	**624**	**4,620,769**	**4,351,057**	—	**£269,712**

TABLE 14.

HOSPITALS HAVING AN **EXCESS OF ORDINARY INCOME** OVER ORDINARY EXPENDITURE.

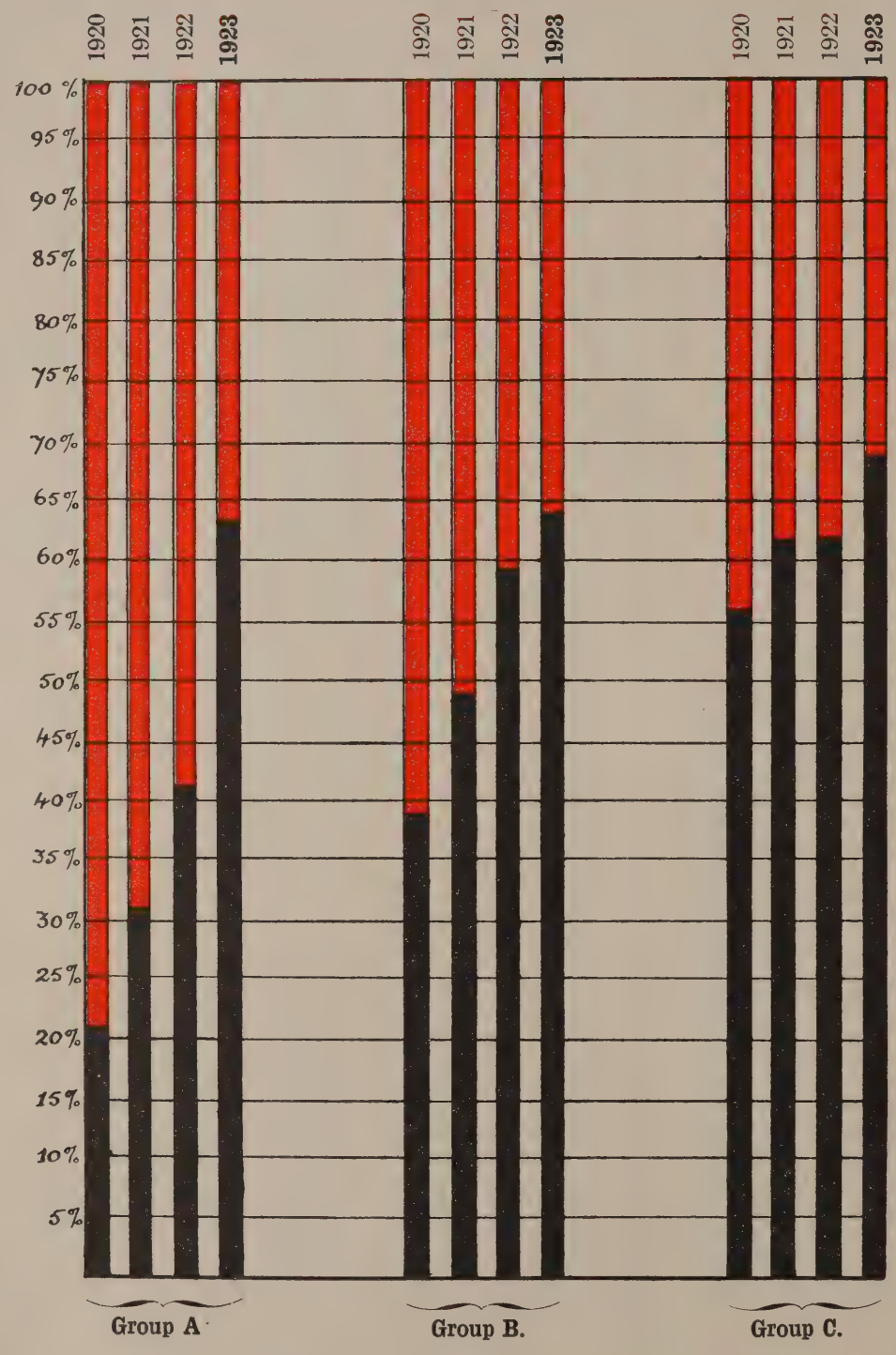
Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Surplus.
Group A	1920	23 (21%)	£694,334	£583,479	£110,855
	1921	33 (31%)	855,463	774,583	80,880
	1922	45 (41%)	1,139,441	998,962	140,479
	1923	**73 (63%)**	**2,005,179**	**1,723,692**	**281,487**
Group B	1920	64 (39%)	423,599	362,103	61,496
	1921	81 (49%)	514,732	448,963	65,769
	1922	96 (59%)	638,788	544,553	94,235
	1923	**118 (64%)**	**728,719**	**603,193**	**125,526**
Group C	1920	168 (56%)	281,274	234,742	46,532
	1921	192 (62%)	318,245	268,566	49,679
	1922	195 (62%)	336,431	282,985	53,446
	1923	**224 (69%)**	**385,712**	**327,715**	**57,997**
Total	1920	255 (45%)	£1,399,207	£1,180,324	£218,883
	1921	306 (53%)	1,688,440	1,492,112	196,328
	1922	336 (57%)	2,114,660	1,826,500	288,160
	1923	**415 (67%)**	**3,119,610**	**2,654,600**	**465,010**

TABLE 15.

HOSPITALS HAVING AN **EXCESS OF ORDINARY EXPENDITURE** OVER ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.
Group A	1920	84 (79%)	£1,816,634	£2,375,550	£558,916
	1921	75 (69%)	1,744,429	2,182,180	437,751
	1922	64 (59%)	1,545,263	1,800,173	254,910
	1923	**42 (37%)**	**1,002,941**	**1,142,683**	**139,742**
Group B	1920	100 (61%)	544,227	643,505	99,278
	1921	83 (51%)	471,570	553,439	81,869
	1922	68 (41%)	354,041	397,450	43,409
	1923	**66 (36%)**	**356,281**	**396,086**	**39,805**
Group C	1920	133 (44%)	212,875	236,520	23,645
	1921	117 (38%)	189,338	215,975	26,637
	1922	119 (38%)	161,447	179,373	17,926
	1923	**101 (31%)**	**141,937**	**157,688**	**15,751**
Total	1920	317 (55%)	£2,573,736	£3,255,575	£681,839
	1921	275 (47%)	2,405,337	2,951,594	546,257
	1922	251 (43%)	2,060,751	2,376,996	316,245
	1923	**209 (33%)**	**1,501,159**	**1,696,457**	**195,298**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—
ORDINARY INCOME ... ... Shown in Black.
ORDINARY EXPENDITURE ... Shown in Red.



Illustrating Tables 14 *and* 15.

TABLE 16.

SURPLUS OR DEFICIT BETWEEN ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income per available bed.	Ordinary Expenditure per available bed.	Surplus (+) or Deficit (—)
Group A ...	1919	108	20,180	£95	£116	—£21
	1920	107	20,184	124	147	— 23
	1921	108	20,525	127	144	— 17
	1922	109	20,960	128	134	— 6
	1923	**115**	**22,071**	**136**	**130**	+ **6**
Group B ...	1919	165	8,476	90	99	— 9
	1920	164	8,437	115	119	— 4
	1921	164	8,363	118	120	— 2
	1922	164	8,436	118	112	+ 6
	1923	**184**	**9,206**	**118**	**109**	+ **9**
Group C ...	1919	327	4,858	85	84	+ 1
	1920	301	4,271	116	110	+ 6
	1921	309	4,468	114	108	+ 6
	1922	314	4,572	109	101	+ 8
	1923	**325**	**4,801**	**110**	**101**	+ **9**
Total	1919	600	33,514	£92	£107	—£15
	1920	572	32,892	121	135	— 14
	1921	581	33,356	123	133	— 10
	1922	587	33,968	123	124	— 1
	1923	**624**	**36,078**	**128**	**121**	+ **7**

TABLE 17.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hospitals.	Available beds.	Ordinary Income.		Ordinary Expenditure.		Surplus per available bed.
			Total.	Per available bed.	Total.	Per available bed.	
General Hospitals—							
Group A	98	18,836	£2,577,310	£137	£2,503,574	£133	£4
„ **B**	128	6,420	710,903	111	655,065	102	9
„ **C**	295	4,234	450,332	106	411,236	97	9
Total	**521**	**29,490**	**£3,738,545**	**£127**	**£3,569,875**	**£121**	**£6**
Special Hospitals—							
Group A	17	3,235	£430,810	£133	£362,801	£112	£21
„ **B**	56	2,786	374,097	131	344,214	124	7
„ **C**	30	567	77,317	136	74,167	131	5
Total	**103**	**6,588**	**£882,224**	**£134**	**£781,182**	**£119**	**£15**

ORDINARY INCOME AND ORDINARY EXPENDITURE PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.

Illustrating Table 16.

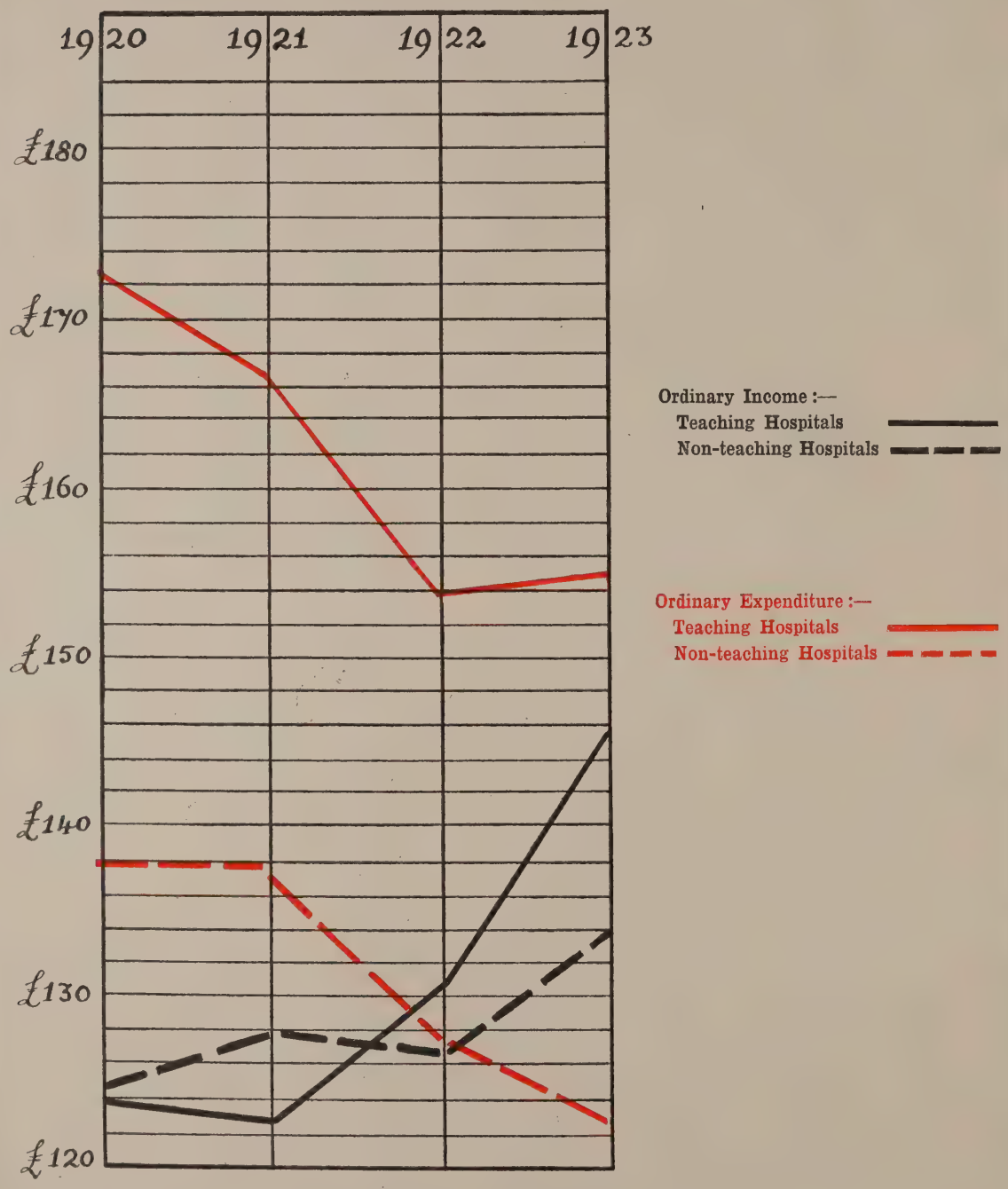
TABLE 18.

ORDINARY INCOME AND EXPENDITURE OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND & WALES.

Hospitals.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Deficit (—) or surplus (+) per *occupied* bed.
A	1920	£33,976	£52,436	£127·25	£196·38	£69·13 (—)
	1921	36,136	50,194	138·98	193·05	54·07 (—)
	1922	33,529	46,686	122·55	170·64	48·09 (—)
	1923	**37,630**	**45,783**	**134·12**	**163·18**	**29·06** (—)
B	1920	24,361	36,983	140·00	214·84	74·84 (—)
	1921	23,389	36,844	135·84	213·99	78·15 (—)
	1922	24,640	34,902	135·50	191·93	56·43 (—)
	1923	**24,468**	**33,527**	**129·10**	**176·92**	**47·82** (—)
C	1920	54,684	80,978	163·23	241·72	78·49 (—)
	1921	56,898	75,754	179·49	238·97	59·48 (—)
	1922	60,613	61,132	204·08	205·83	1·75 (—)
	1923	**58,264**	**66,687**	**185·55**	**212·38**	**26·83** (—)
D	1920	23,927	40,417	131·46	222·07	90·61 (—)
	1921	28,108	34,195	157·18	191·25	34·07 (—)
	1922	29,118	33,822	161·05	187·07	26·02 (—)
	1923	**28,659**	**34,519**	**157·73**	**181·00**	**23·27** (—)
E	1920	31,260	52,874	100·83	170·56	69·73 (—)
	1921	32,129	51,589	95·91	154·00	58·09 (—)
	1922	43,340	46,038	127·10	135·01	7·91 (—)
	1923	**56,220**	**50,076**	**160·17**	**142·66**	**17·51** (+)
F	1920	22,849	45,217	103·38	204·60	101·22 (—)
	1921	22,834	38,367	111·93	188·07	76·14 (—)
	1922	32,175	29,886	153·21	142·31	10·90 (+)
	1923	**39,396**	**37,286**	**168·36**	**159·34**	**9·02** (+)
G	1920	27,209	60,206	111·05	245·73	134·68 (—)
	1921	43,144	51,242	160·39	190·49	30·10 (—)
	1922	40,629	50,010	147·42	181·46	34·04 (—)
	1923	**44,740**	**53,317**	**155·51**	**185·32**	**29·81** (—)
H	1920	25,912	44,768	112·66	194·64	81·98 (—)
	1921	24,249	42,703	104·39	183·83	79·44 (—)
	1922	32,450	37,538	135·69	156·96	21·27 (—)
	1923	**30,028**	**37,570**	**124·14**	**155·32**	**31·18** (—)
I	1920	83,737	105,354	154·21	195·86	41·65 (—)
	1921	75,882	100,981	143·44	190·89	47·45 (—)
	1922	77,263	100,541	147·32	191·67	44·35 (—)
	1923	**96,134**	**98,130**	**177·70**	**181·39**	**3·69** (—)
J	1920	66,932	99,192	171·62	254·34	82·72 (—)
	1921	45,605	95,025	106·31	221·50	115·19 (—)
	1922	62,685	90,723	140·87	203·87	63·00 (—)
	1923	**73,335**	**91,161**	**159·08**	**197·75**	**38·67** (—)
K	1920	112,699	108,389	221·84	213·36	8·48 (+)
	1921	96,788	103,841	188·82	202·58	13·76 (—)
	1922	89,960	91,555	171·22	174·26	3·04 (—)
	1923	**92,180**	**87,795**	**171·53**	**163·37**	**8·16** (+)
L	1920	21,756	33,733	123·61	191·66	68·05 (—)
	1921	40,917	39,349	235·15	226·14	9·01 (+)
	1922	35,333	39,991	200·76	227·22	26·46 (—)
	1923	**37,943**	**37,130**	**224·51**	**219·70**	**4·81** (+)
M	1920	22,597	24,450	159·13	172·18	13·05 (—)
	1921	23,721	27,949	145·53	171·47	25·94 (—)
	1922	23,254	24,551	122·39	129·32	6·93 (—)
	1923	**23,464**	**23,996**	**131·08**	**134·06**	**2·98** (—)
*N	**1923**	**67,081**	**57,414**	**210·55**	**180·21**	**30·34** (+)
Totals	1920	£551,899	£784,997	£148·15	£210·73	£62·58 (—)
	1921	549,800	748,033	145·60	198·10	52·50 (—)
	1922	584,989	687,375	152·42	179·10	26·68 (—)
	1923	**709,542**	**754,391**	**165·55**	**176·01**	**10·46** (—)

* Recognised as a Medical School during 1923.

ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED OF HOSPITALS CONSTITUTING GROUP A.



Illustrating Table 19.

TABLE 19.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF THE TEACHING AND NON-TEACHING HOSPITALS IN GROUP A SHOWN SEPARATELY.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income.		Ordinary Expenditure.		Surplus (+) or Deficit (−) per *available* bed.
				Total.	Per *available* bed.	Total.	Per *available* bed.	
Medical School Hospitals	1920	13	4,467	£551,899	£124*	£784,997	£173*	—£49*
	1921	13	4,477	549,800	123	748,033	167	— 44
	1922	13	4,465	584,989	131	687,375	154	— 23
	1923	**14**	**4,861**	**709,542**	**146**	**754,391**	**155**	**— 9**
Non-teaching Hospitals	1920	94	15,717	1,959,069	125	2,174,032	138	— 13
	1921	95	16,048	2,050,092	128	2,208,730	138	— 10
	1922	96	16,495	2,099,715	127	2,111,760	128	— 1
	1923	**101**	**17,210**	**2,298,578**	**134**	**2,111,984**	**123**	**+ 11**

* Calculated to the nearest £.

SECTION 4.

ANALYSIS OF SOME OF THE SOURCES OF ORDINARY INCOME.

INVESTED FUNDS.

No uniformity is observed by the Hospitals in showing the amount of their Invested Funds.

The following gives the methods at present employed :—

Hospitals.	Investments shown at Market Value.	Investments shown at cost.	Investments shown at Nominal Value.	Basis not stated and Hospitals using more than one way.
Group A	37=32%	35=31%	15=13%	28=24%
Group B	33=18%	53=29%	36=19%	62=34%
Group C	42=13%	54=17%	81=25%	148=45%

Where Market Value is shown in addition to either Cost or Nominal Value, the Market Value has been taken and the Hospitals included in the first column of above Table.

It is satisfactory to note that the number of those giving market value is an increasing one. The total figure which Table 20 gives must, therefore, be taken as approximate only, and almost certainly in excess of market value. The increase in the total for the year 1923 of £807,451 is due partly to the fact that a larger number of Hospitals is included in the review. It is eminently desirable that the Voluntary Hospitals as an organised system should be able to state the market value of their various securities, and what proportion is available for :—

A.—General purposes.
B.—Endowment or special purposes.

At present this is not possible.

The steady rise in the amount of investments held and of the interest derived therefrom—most marked in the Group A Hospitals—shows that the English and Welsh Hospitals as a whole have been able to more than make good any reduction of their invested funds, due to the sale of securities to meet capital or current expenditure during the last four years, probably the most difficult in the history of the Voluntary Hospitals.

WORKMEN'S CONTRIBUTIONS.

The amounts derived from Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes have approximately doubled during the past four years and are still growing. In the face of trade depression this is a remarkable fact, and significant of the regard which those who use the Hospitals have for them.

PATIENTS' CONTRIBUTIONS.

Patients' Contributions also show a remarkable rise for the four-year period ; nor is there any sign that the maximum has yet been reached in this source of support. At the same time, we must be prepared to recognise that if Contributory Schemes grow and the conditions of admission tend to become more favourable for subscribing members, the amount derivable from the present class of hospital patient must have a tendency to fall. To what extent this will be counterbalanced by the increase in the accommodation which the Hospitals, especially in Classes B and C, are now providing for paying patients, time alone can show.

INCOME FROM PUBLIC SERVICES.

Tables 23 and 24 give an analysis of the income derived from Public Services. If the payments from the War Office and the Ministry of Pensions, which have naturally fallen year by year, and which will disappear as time goes on, are eliminated, the receipts from the remaining sources, which may be regarded as more or less of a permanent character, are found to have risen from £268,795 in 1920 to £416,728 in 1923. A graph is given on the basis of the available bed, from which it will be seen that this increase is principally among the Hospitals in the A Group.

Attention may be called to Table 24 where the growth of Infant Welfare and Maternity Work is noticeable especially in Group B. Group C shows a diminution, it is true, but this is mainly accounted for by the enlargement of some of the Hospitals in Group C, resulting in their inclusion in Group B. It is permissible to refer with satisfaction to this growth, for, unlike almost all other hospital work, it does not necessarily connote a greater amount of sickness, but rather better facilities for the prevention of invalidity.

It is also satisfactory to note, so far as it is any indication of a fall in sickness, a diminution in the amount spent on Venereal Diseases, though it is possible that a portion of this reduction is due to an effort on the part of the centres to exercise a more stringent supervision over expenditure.

One of the main sources of income from Public Services is, of course, payments under the National Health Insurance Act. Probably the amount derived from this source is larger than the total £98,094 given in the Table, as some portion of the £91,408 shown under the heading "Details not given" must be attributed to payments by Approved Societies.

In view of the growing demand made by the Public Authorities upon the Voluntary Hospitals for services in connection with Venereal Diseases, Tuberculosis, Maternity and Child Welfare, School Medical Treatment and National Health, it would be most desirable in every way for monies derived in respect of each, to be shown separately in the accounts published by each Hospital.

Table 25 analyses Payments by or on behalf of patients. This Table is given for the purpose of comparison with the London figures. It is taken out on a basis similar to that used by King Edward's Hospital Fund for London.

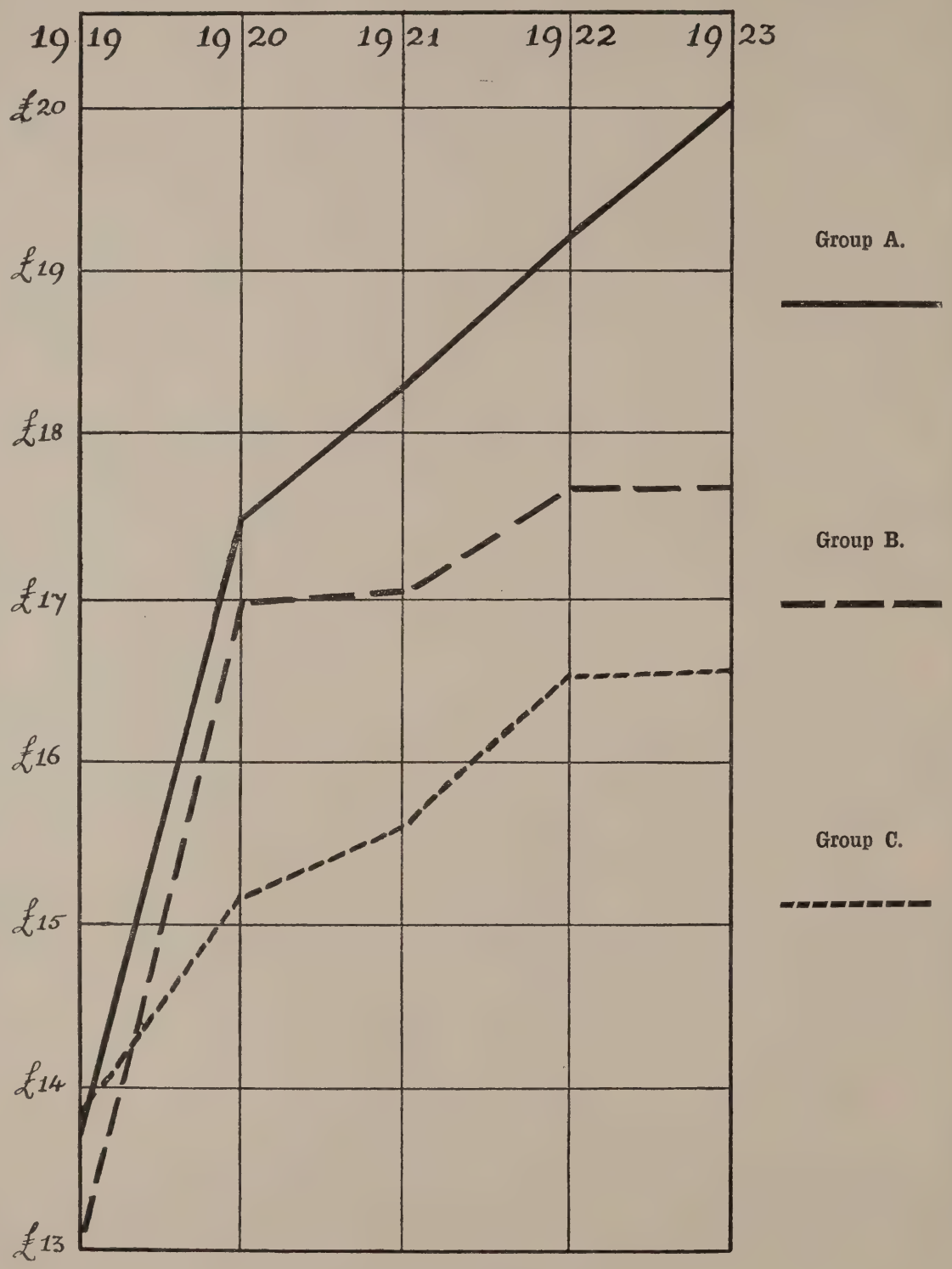
SUBSCRIPTIONS AND DONATIONS.

There is a slight fall in the total amount derived from subscriptions. On the other hand, there is a slight increase noticeable in the figures of the large Hospitals, and the diminution in the figures of the Group B and Group C Hospitals is not considerable. To have maintained this source of income during the past four years shows the grip which the Voluntary Hospitals have upon the sympathy of every class of the community. Confidence in the truth of this statement is not lessened by the figures shown under the heading "Donations."

MEDICAL SCHOOL HOSPITALS.

Table 29 analyses some of the sources of Ordinary Income of the fourteen Hospitals associated with Medical Schools. The upward tendency is most noticeable in the amount derived from Workmen's Contributions and from Public Services. In all except Patients' Contributions, a majority of the Hospitals show increases for the year 1923.

AMOUNT PER AVAILABLE BED DERIVED FROM INTEREST ON INVESTMENTS.



Illustrating Table 20.

TABLE 20.

INVESTED FUNDS AND THE INTEREST THEREFROM.

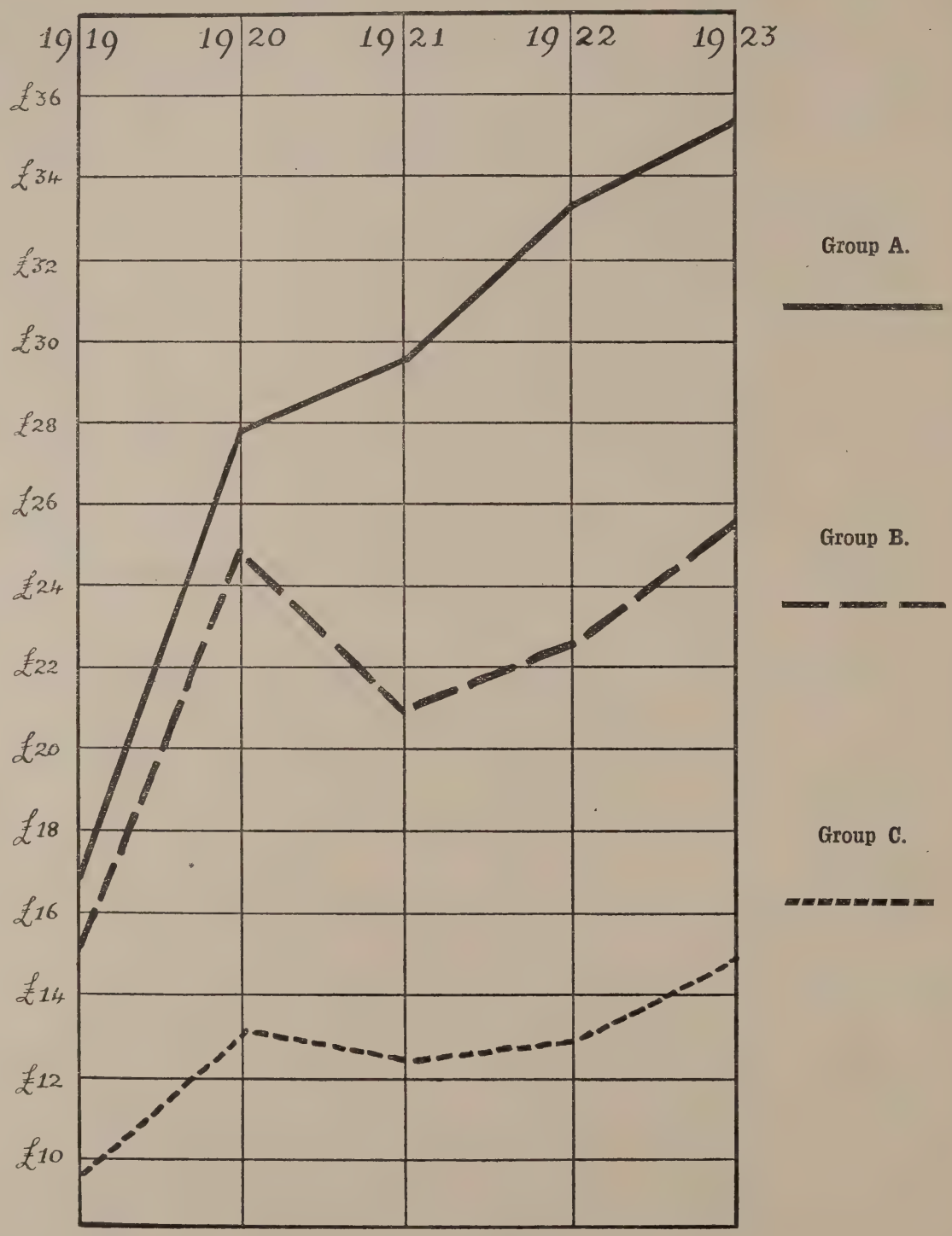
Hospitals.	Year.	No. of Hospitals.	Invested Funds.		Interest from Investments.	
			Total.	Per available bed.	Total.	Amount per available bed.
Group A	1919	108	£6,966,819	£345	£278,269	£13·78
	1920	107	7,361,452	365	353,310	17·50
	1921	108	8,005,811	390	376,278	18·33
	1922	109	8,645,372	412	403,454	19·24
	1923	**115**	**9,121,016**	**413**	**441,887**	**20·02**
Group B	1919	165	2,729,249	322	110,955	13·09
	1920	164	2,964,987	351	143,364	16·99
	1921	164	3,295,386	394	142,678	17·06
	1922	164	3,378,364	400	149,034	17·66
	1923	**184**	**3,605,286**	**392**	**162,694**	**17·67**
Group C	1919	327	1,231,243	253	67,159	13·83
	1920	301	1,189,418	278	64,870	15·18
	1921	309	1,497,496	335	69,670	15·59
	1922	314	1,627,087	356	75,563	16·52
	1923	**325**	**1,731,972**	**361**	**79,572**	**16·57**
Total	1919	600	£10,927,311	£326	£456,383	£13·61
	1920	572	11,515,857	350	561,544	17·09
	1921	581	12,798,693	383	588,626	17·64
	1922	587	13,650,823	402	628,051	18·48
	1923	**624**	**14,458,274**	**401**	**684,153**	**18·96**

TABLE 21.

WORKMEN'S CONTRIBUTIONS, HOSPITAL SATURDAY FUNDS AND CONTRIBUTORY SCHEMES.

Hospitals.	Year.	No. of Hospitals.	Total Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Amount per available bed.
Group A	1919	108	£341,620	£16·92
	1920	107	563,257	27·90
	1921	108	609,094	29·67
	1922	109	701,673	33·47
	1923	**115**	**784,983**	**35·56**
Group B	1919	165	129,208	15 24
	1920	164	210,548	24·95
	1921	164	176,206	21·06
	1922	164	191,153	22·65
	1923	**184**	**235,581**	**25·58**
Group C	1919	327	47,215	9·71
	1920	301	56,728	13·28
	1921	309	56,111	12·55
	1922	314	59,547	13·02
	1923	**325**	**72,058**	**15·00**
Total	1919	600	£518,043	£15·45
	1920	572	830,533	25·25
	1921	581	841,411	25·22
	1922	587	952,373	28·03
	1923	**624**	**1,092,622**	**30·28**

AMOUNT PER AVAILABLE BED DERIVED FROM WORKMEN'S CONTRIBUTIONS AND CONTRIBUTORY SCHEMES.



Illustrating Table 21.

TABLE 22.

PATIENTS' CONTRIBUTIONS (including donations from "Grateful Patients.")

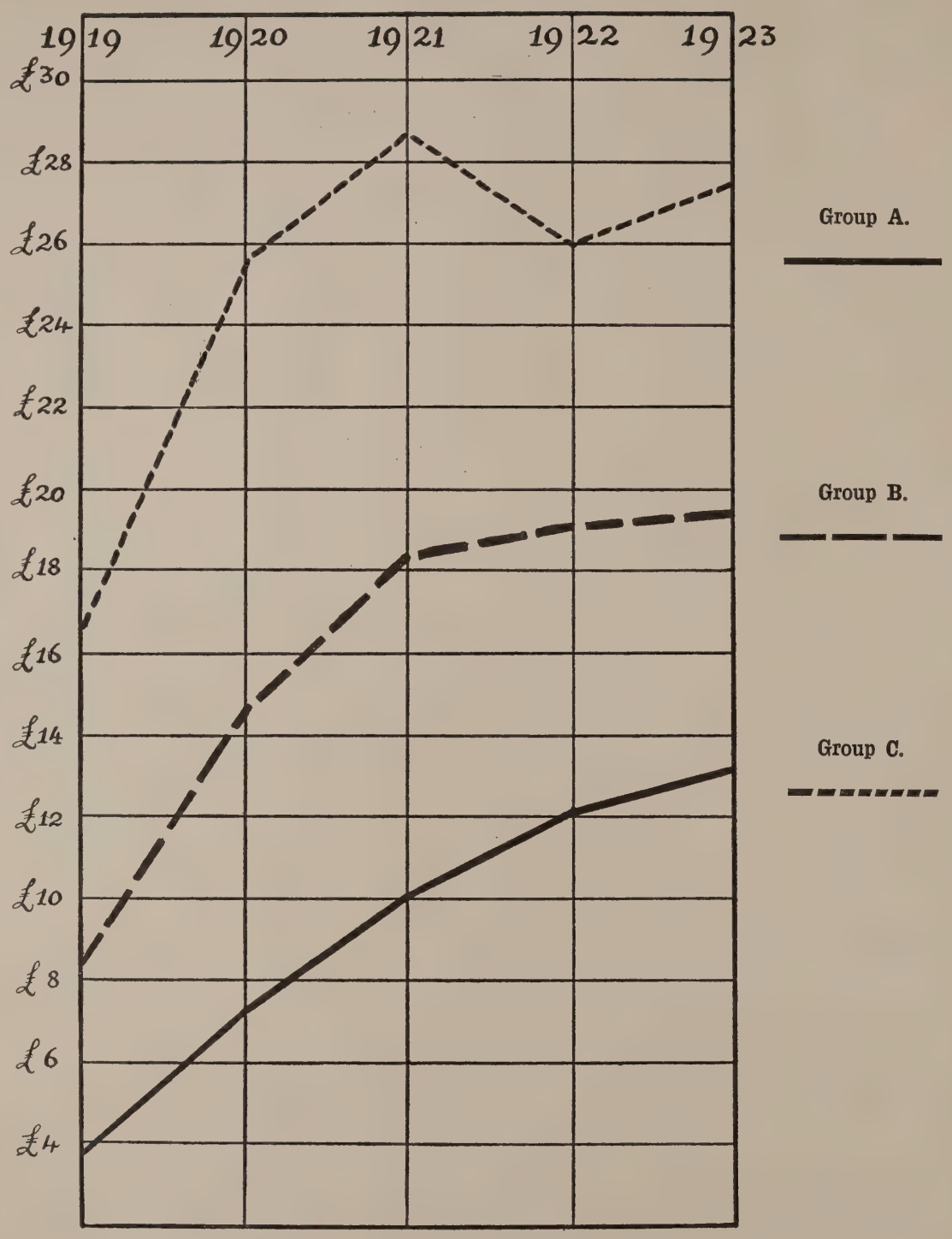
Hospitals	Year.	No. of Hospitals.	Total Patients' Contributions.	Amount per available bed.
Group A	1919	108	£ 78,946	£ 3·91
	1920	107	149,508	7·40
	1921	108	209,396	10·20
	1922	109	256,175	12·22
	1923	**115**	**291,617**	**13·21**
Group B	1919	165	72,666	8·57
	1920	164	125,099	14·82
	1921	164	153,750	18·38
	1922	164	161,505	19·14
	1923	**184**	**178,514**	**19·39**
Group C	1919	327	81,317	16·73
	1920	301	109,646	25·67
	1921	309	128,876	28·83
	1922	314	118,949	26·01
	1923	**325**	**131,806**	**27·41**
Total	1919	600	£ 232,929	£ 6·95
	1920	572	384,253	11·68
	1921	581	492,022	14·75
	1922	587	536,629	15·79
	1923	**624**	**601,937**	**16·67**

TABLE 23.

INCOME FROM PUBLIC SERVICES.

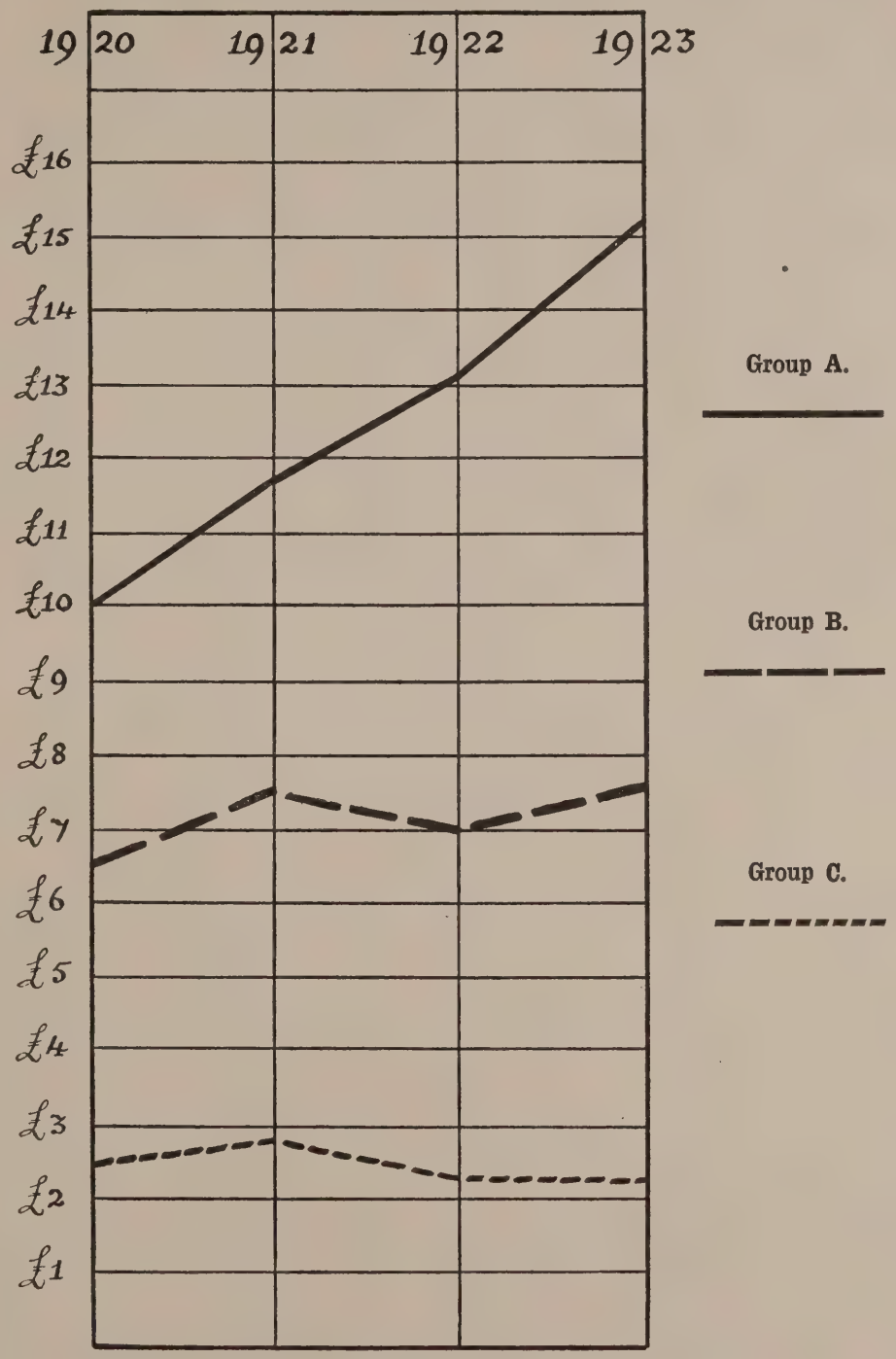
Hospitals.	Year.	No. of Hospitals.	Total Income from Public Services.	Amount per available bed.
Group A	1919	108	£ 441,103	£ 21·85
	1920	107	436,269	21·61
	1921	108	440,760	21·47
	1922	109	397,189	17·99
	1923	**115**	**400,954**	**18·16**
Group B	1919	165	108,545	12·80
	1920	164	116,981	13·86
	1921	164	105,176	12·57
	1922	164	83,169	9·85
	1923	**184**	**80,964**	**8·79**
Group C	1919	327	21,164	4·35
	1920	301	17,075	3·99
	1921	309	16,972	3·79
	1922	314	12,505	2·73
	1923	**325**	**12,345**	**2·57**
Total	1919	600	£ 570,812	£ 17·03
	1920	572	570,325	17·35
	1921	581	562,908	16·87
	1922	587	492,863	14·53
	1923	**624**	**494,263**	**13·69**

AMOUNT PER AVAILABLE BED DERIVED FROM PATIENTS' CONTRIBUTIONS.



Illustrating Table 22.

AMOUNT PER AVAILABLE BED DERIVED FROM PUBLIC SERVICES (EXCLUDING WAR OFFICE, ADMIRALTY AND MINISTRY OF PENSIONS).



See page 35.

TABLE 24.

ANALYSIS OF THE SOURCES OF INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	War Office or Admiralty.	Ministry of Pensions.	Infant Welfare and Maternity Work.	Venereal Diseases.	Tuberculosis cases.	Education Authorities.	National Health Insurance Act.	Details not given.
Group A ...	1920	£ 9,957	£ 223,349	£ 3,011	£ 95,965	£ 11,365	£ 10,688	£ 28,200	£ 53,734
	1921	3,879	195,938	7,960	95,793	50,410	10,864	33,451	42,465
	1922	1,713	119,408	6,582	97,001	51,630	11,103	29,825	79,927
	1923	**953**	**64,109**	**8,828**	**91,380**	**55,338**	**17,676**	**85,874**	**76,796**
Group B ...	1920	1,390	60,530	10,553	19,066	4,547	3,668	8,699	8,528
	1921	1,019	41,034	17,045	17,717	10,143	4,002	5,937	8,279
	1922	197	23,340	13,970	13,319	14,599	3,801	1,994	11,949
	1923	**86**	**11,010**	**20,599**	**11,641**	**11,461**	**3,231**	**10,384**	**12,552**
Group C ...	1920	—	6,304	4,958	1,907	932	868	2,040	66
	1921	49	4,347	5,853	1,716	29	776	2,306	1,896
	1922	19	1,718	2,741	1,245	2,436	1,439	663	2,244
	1923	**10**	**1,367**	**2,761**	**567**	**2,220**	**1,524**	**1,836**	**2,060**
Total ...	1920	£ 11,347	£ 290,183	£ 18,522	£ 116,938	£ 16,844	£ 15,224	£ 38,939	£ 62,328
	1921	4,947	241,319	30,858	115,226	60,582	15,642	41,694	52,640
	1922	1,929	144,466	23,293	111,565	68,665	16,343	32,482	94,120
	1923	**1,049**	**76,486**	**32,188**	**103,588**	**69,019**	**22,431**	**98,094**	**91,408**

TABLE 25.

PAYMENTS BY OR ON BEHALF OF PATIENTS.

Hospitals.	Year.	No. of Hospitals.	Total Payments by or on behalf of Patients.	Amount per available bed.
Group A	1919	108	£ 520,049	£ 25·77
	1920	107	585,777	29·02
	1921	108	650,156	31·67
	1922	109	653,364	31·17
	1923	**115**	**692,063**	**31·35**
Group B	1919	165	181,211	21·37
	1920	164	242,080	28·69
	1921	164	258,926	30·96
	1922	164	244,674	29·00
	1923	**184**	**259,478**	**28·18**
Group C	1919	327	102,481	21·09
	1920	301	126,721	29·67
	1921	309	145,848	32·64
	1922	314	131,454	28·53
	1923	**325**	**144,151**	**30·02**
Total	1919	600	£ 803,741	£ 23·98
	1920	572	954,578	29·02
	1921	581	1,054,930	31·62
	1922	587	1,029,492	30·30
	1923	**624**	**1,095,692**	**30·37**

TABLE 26.

INCOME DERIVED FROM SUBSCRIPTIONS AND DONATIONS.

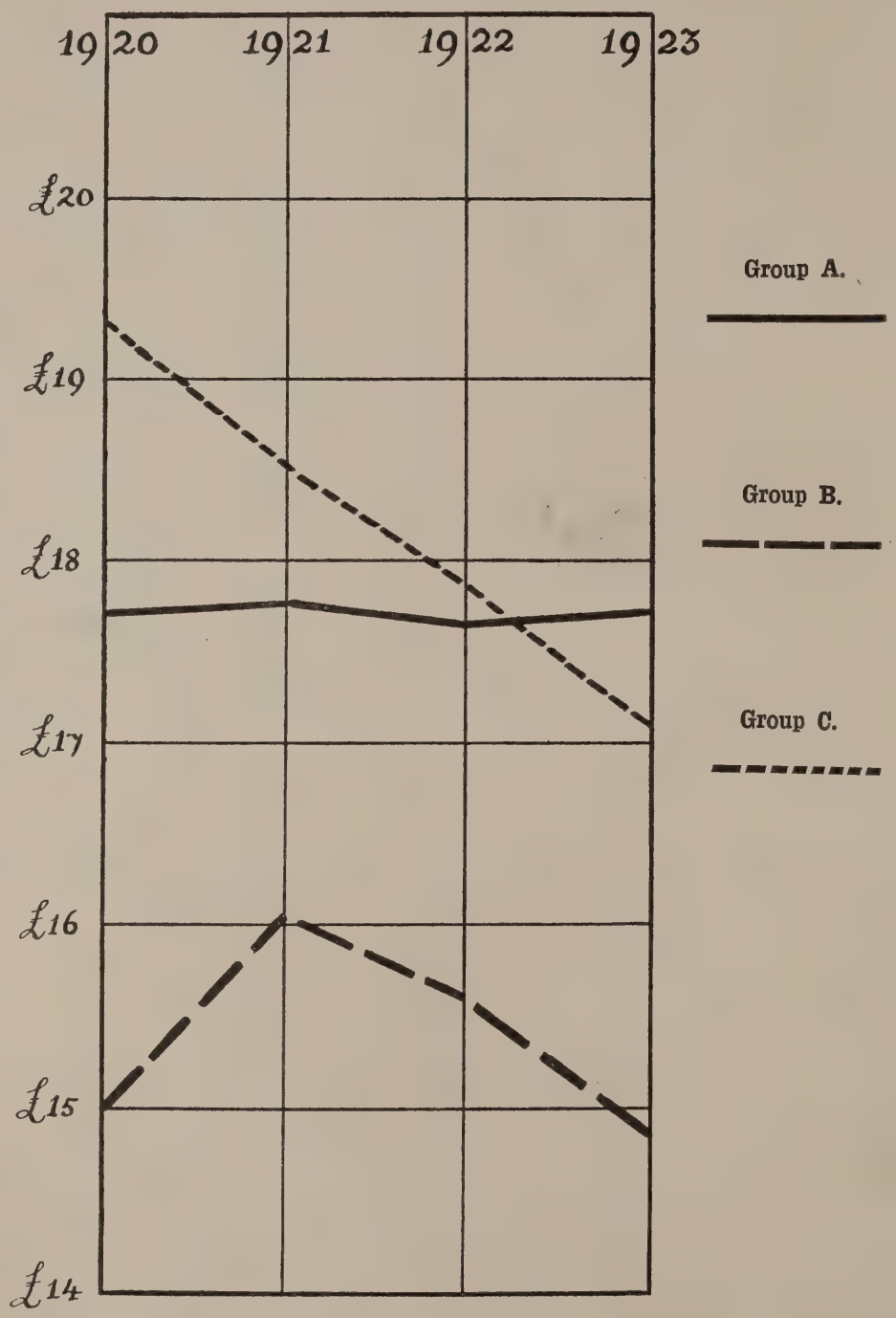
Hospitals.	Year.	No. of Hospitals.	Subscriptions.		Donations (including Entertainments, etc.)	
			Total.	Amount per available bed.	Total.	Amount per available bed.
Group A	1920	107	£358,059	£17·73	£351,892	£17·43
	1921	108	365,241	17·79	423,039	20·61
	1922	109	370,624	17·68	403,335	19·24
	1923	**115**	**391,639**	**17·74**	**466,526**	**21·13**
Group B	1920	164	126,822	15·03	123,526	14·64
	1921	164	134,484	16·08	200,811	24·01
	1922	164	131,995	15·64	189,144	22·42
	1923	**184**	**137,282**	**14·90**	**245,103**	**26·62**
Group C	1920	301	82,695	19·36	71,937	16·84
	1921	309	82,860	18·54	117,712	24·10
	1922	314	81,847	17·90	126,022	27·56
	1923	**325**	**82,209**	**17·12**	**124,624**	**25·93**
Total	1920	572	£567,576	£17·27	£547,355	£16·64
	1921	581	582,585	17.46	741,562	22·23
	1922	587	584,466	17·20	718,501	21·15
	1923	**624**	**611,130**	**16·93**	**836,253**	**23·17**

TABLE 27.

CONGREGATIONAL COLLECTIONS, INCLUDING HOSPITAL SUNDAY FUNDS.

Hospitals.	Year.	No. of Hospitals.	Total Congregational Collections, etc.	Amount per available bed.
Group A	1922	109	£102,342	£4·88
	1923	**115**	**106,741**	**4·83**
Group B	1922	164	36,379	4·31
	1923	**184**	**37,032**	**4·02**
Group C	1922	314	19,745	4·31
	1923	**325**	**19,598**	**4·08**
Total	1922	587	£158,466	£4·68
	1923	**624**	**163,371**	**4·52**

AMOUNT PER AVAILABLE BED DERIVED FROM ANNUAL SUBSCRIPTIONS.



Illustrating Table 26.

TABLE 28.

SUMMARY OF ANALYSIS OF ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Amount per available bed received from :—						
			Interest from Investments.	Workmen's Contributions, etc.	Patients' Contributions.	Income from Public Services.	Subscriptions.	Donations.	Total amount from the six sources.
Group A ...	1919	108	£13·78	£16·92	£3·91	£21·85	—	—	£56·46
	1920	107	17·50	27·90	7·40	21·61	£17·73	£17·43	109·57
	1921	108	18·33	29·67	10·20	21·47	17·79	20·61	118·07
	1922	109	19·24	33·47	12·22	17·99	17·68	19·24	119·84
	1923	**115**	**20·02**	**35·56**	**13·21**	**18·16**	**17·74**	**21·13**	**125·82**
Group B ...	1919	165	13·09	15·24	8·57	12·80	—	—	49·70
	1920	164	16·99	24·95	14·82	13·86	15·03	14·64	100·29
	1921	164	17·06	21·06	18·38	12·57	16·08	24·01	109·16
	1922	164	17·66	22·65	19·14	9·85	15·64	22·42	107·36
	1923	**184**	**17·67**	**25·58**	**19·39**	**8·79**	**14·90**	**26·62**	**112·95**
Group C ...	1919	327	13·83	9·71	16·73	4·35	—	—	44·62
	1920	301	15·18	13·28	25·67	3·99	19·36	16·84	94·32
	1921	309	15·59	12·55	28·83	3·79	18·54	24·10	103·40
	1922	314	16·52	13·02	26·01	2·73	17·90	27·56	103·74
	1923	**325**	**16·57**	**15·00**	**27·41**	**2·57**	**17·12**	**25·93**	**104·60**
Total	1919	600	£13·61	£15·45	£6·95	£17·03	—	—	£53·04
	1920	572	17·09	25·25	11·68	17·35	£17·27	£16·64	105·28
	1921	581	17·64	25·22	14·75	16·87	17·46	22·23	114·17
	1922	587	18·48	28·03	15·79	14·53	17·20	21·15	115·18
	1923	**624**	**18·96**	**30·28**	**16·67**	**13·69**	**16·93**	**23·17**	**119·70**

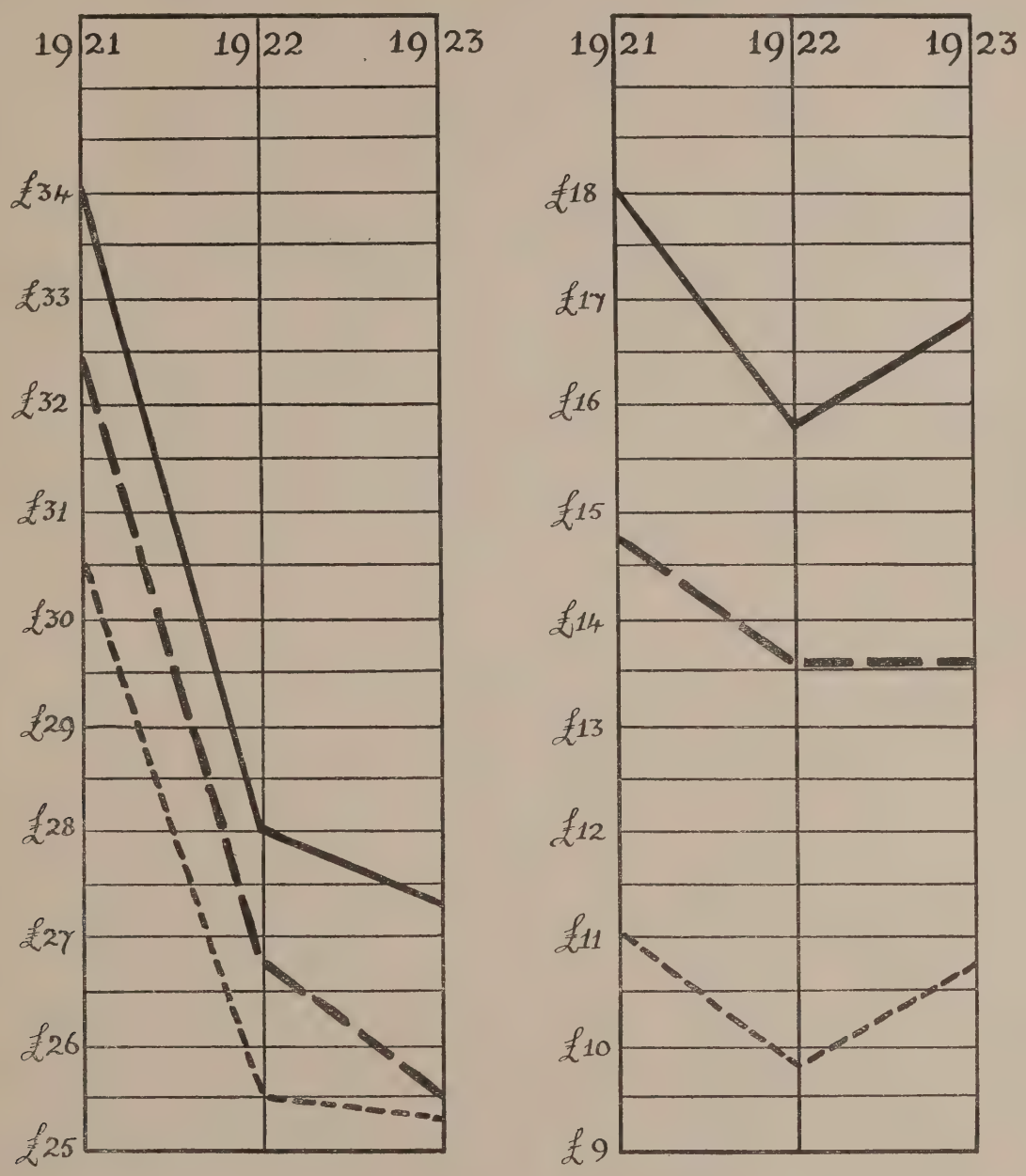
TABLE 29.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospitals.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
A	1920	£6,551	£5,104	£5,546	£9,129
	1921	7,084	4,325	10,427	9,086
	1922	7,368	4,000	11,034	6,934
	1923	**7,794**	**3,720**	**11,661**	**8,236**
B	1920	3,428	3,871	4,423	6,100
	1921	3,363	3,323	6,974	4,841
	1922	4,019	3,262	6,563	4,866
	1923	**3,687**	**3,006**	**7,035**	**4,907**
C	1920	13,300	15,095	603	7,384
	1921	12,151	16,384	59	781
	1922	13,528	16,115	3,673	7,061
	1923	**12,058**	**16,450**	**1,716**	**8,070**
D	1920	4,391	8,469	717	511
	1921	4,402	6,000	2,486	898
	1922	4,597	7,744	2,744	2,195
	1923	**4,572**	**8,153**	**2,348**	**2,721**
E	1920	4,259	9,126	—	3,613
	1921	4,287	10,305	—	1,641
	1922	4,618	22,666	2,368	2,754
	1923	**4,798**	**31,565**	**1,870**	**3,448**
F	1920	2,689	4,714	202	5,819
	1921	2,916	7,330	210	848
	1922	3,210	16,418	2,369	2,234
	1923	**3,441**	**21,441**	**1,855**	**2,730**
G	1920	2,841	5,088	—	284
	1921	6,616	4,361	2,968	—
	1922	7,511	5,945	8,529	—
	1923	**11,852**	**4,772**	**8,654**	—
H	1920	6,075	4,845	352	575
	1921	5,318	4,258	3,794	339
	1922	5,056	5,374	8,050	1,447
	1923	**4,896**	**5,099**	**5,940**	**3,797**
I	1920	18,119	1,577	8,558	13,073
	1921	18,229	2,220	10,809	13,875
	1922	18,016	2,186	10,378	8,757
	1923	**18,327**	**2,491**	**11,878**	**8,398**
J	1920	6,996	24,918	2,449	10,453
	1921	6,953	25,242	3,284	8,960
	1922	5,754	27,992	3,511	7,708
	1923	**10,891**	**30,392**	**3,748**	**6,856**
K	1920	9,356	44,952	1,446	13,818
	1921	8,493	44,075	1,978	10,517
	1922	8,849	43,648	2,324	9,517
	1923	**9,321**	**44,662**	**2,030**	**14,098**
L	1920	2,830	939	282	6,347
	1921	2,255	16,281	1,285	8,718
	1922	2,501	20,479	2,098	2,715
	1923	**2,666**	**21,436**	**3,660**	**3,294**
M	1920	3,381	800	974	7,380
	1921	3,584	1,321	884	6,837
	1922	3,467	1,779	986	6,488
	1923	**3,773**	**1,824**	**952**	**6,175**
N*	**1923**	**7,671**	**24,178**	**4,940**	**841**
Totals	1920	£84,216	£129,498	£25,552	£84,486
	1921	85,651	145,425	45,158	67,341
	1922	88,494	177,608	64,627	62,676
	1923	**105,747**	**219,189**	**68,287**	**73,571**

* Recognised as a Medical School during 1923.

EXPENDITURE PER AVAILABLE BED.



Illustrating Table 30.

ANALYSIS OF THE PRINCIPAL ITEMS

The figures in Table 30 have admittedly only a limited value, but they are satisfactory to this extent, that they indicate a steady decline in expenditure per available bed.

For comparative purposes between Hospitals or even groups of Hospitals they can be only taken as rough guides. A much greater degree of detail in the setting forth of Hospital work and Hospital expenditure is necessary, before the full benefit of the analysis and tabulation of figures for comparative purposes and as a help to Administration can be obtained. For example, the available bed is obviously an unsatisfactory basis in considering the item "Provisions." A more reasonable one would be, were it possible to obtain it, the total number fed subdivided into various classes, viz., patients, staff, etc. Such a subdivision would at any rate provide comparable data, but until the undoubtedly increasing interest in matters of this kind results in improved statistical and accounting methods it is not possible to do more than make use of the available bases, imperfect as they are. With this qualification it is justifiable to express satisfaction that, as a whole,

TABLE 30.

ANALYSIS OF THE PRINCIPAL ITEMS OF

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Provisions.		Surgery and Dispensary.	
				Total.	Per *available* bed.	Total.	Per *available* bed.
Group A	1921	108	20,525	£699,825	£34·09	£369,462	£18·00
	1922	109	20,960	587,357	28·02	331,407	15·81
	1923	**115**	**22,071**	**603,529**	**27·34**	**371,651**	**16·84**
Group B	1921	159	8,165	265,655	32·54	120,712	14·78
	1922	163	8,403	225,202	26 80	114,744	13·65
	1923	**176**	**8,835**	**225,633**	**25·54**	**120,566**	**13·65**
Group C	1921	280	4,105	125,430	30·56	45,694	11·13
	1922	283	4,223	107,826	25·53	41,406	9·81
	1923	**282**	**4,271**	**108,122**	**25·32**	**45,978**	**10·77**
Total	1921	547	32,795	£1,090,910	£33·26	£535,868	£16·34
	1922	555	33,586	920,385	27·40	487,557	14·52
	1923	**573**	**35,177**	**937,284**	**26·64**	**538,195**	**15·30**

the Table shows a general reduction in items of controllable expenditure. In the figure of the totals of the four headings there is a fall of £1·64 per available bed for the year 1923 compared with the year 1922, and a very remarkable fall of £10·15 when the year 1923 is compared with the year 1921. The slight rise in the item Surgery and Dispensary can readily be understood if we make allowance for the unavoidable expenditure upon new and often expensive forms of treatment.

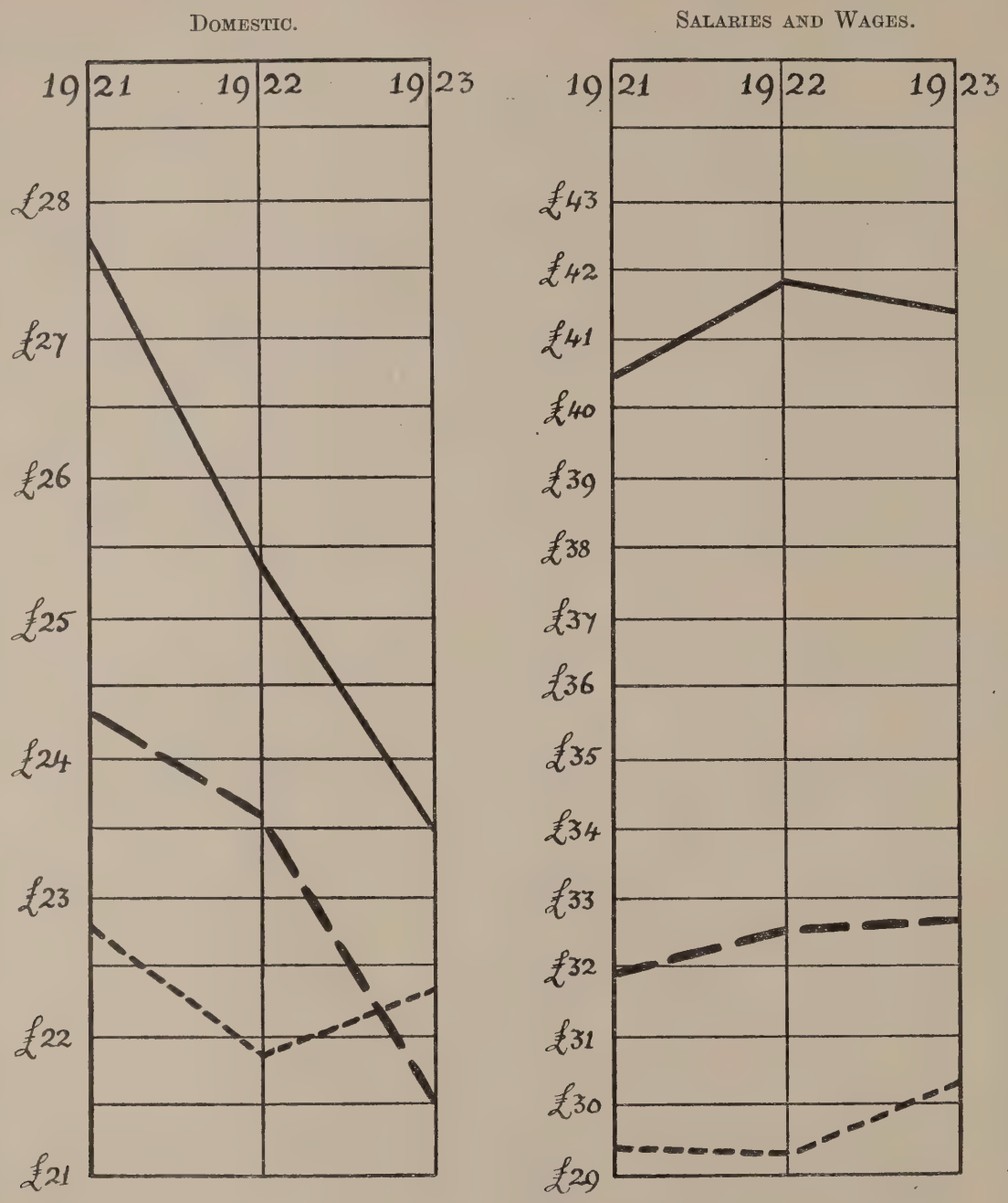
The trend of expenditure in the Medical School group shown in Table 31 differs in no way from that in the Hospitals taken as a whole. Little stress can be laid upon individual variations from the average, as the presence of a special service or a more highly developed Department naturally increases cost.

Table 32 analyses the figures of cost of Fuel and Light at a certain number of Hospitals where the details are sufficiently separated to allow some approximation to the actual expenditure to be arrived at. There, again, a satisfactory fall in cost is apparent.

ORDINARY EXPENDITURE BY GROUP AVERAGES.

Domestic.		Salaries and Wages.		Total Expenditure under the four headings.	
Total.	Per *available* bed.	Total.	Per *available* bed.	Total.	Per *available* bed.
£569,505	£27·75	£831,410	£40·51	£2,470,202	£120.35
532,131	25·39	877,450	41·87	2,328,345	111·09
519,668	**23·54**	**914,095**	**41·42**	**2,408,943**	**109·14**
198,476	24·31	261,075	31·97	845,918	103·60
198,191	23·59	273,653	32·57	811,790	96·61
190,405	**21·55**	**289,179**	**32·73**	**825,783**	**93·47**
93,601	22·80	121,134	29·51	385,859	94·00
92,281	21·85	123,949	29·35	365,462	86·54
95,435	**22·34**	**129,430**	**30·30**	**378,965**	**88·73**
£861,582	£26·27	£1,213,619	£37·01	£3,701,979	£112·88
822,603	24·49	1,275,052	37·96	3,505,597	104·37
805,508	**22·90**	**1,332,704**	**37·89**	**3,613,691**	**102·73**

EXPENDITURE PER AVAILABLE BED.



Group A.

Group B.

Group C.

Illustrating Table 30.

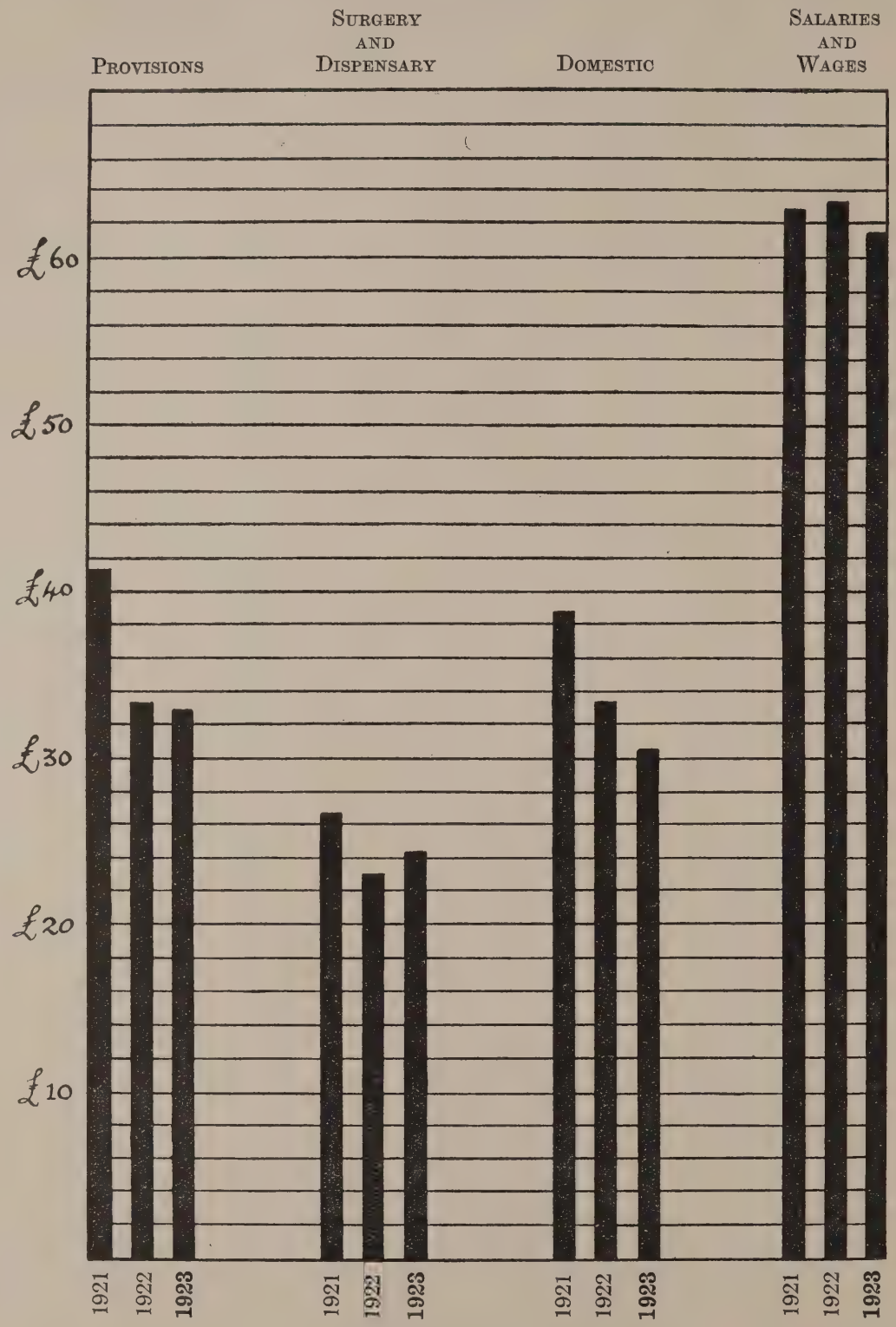
TABLE 31.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE OF THE 14 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.	Total.	Per *occupied* bed.
A ...	1921	260·00	£10,191	£39·2	£7,847	£30·2	£9,700	£37·3	£14,684	£56·5
	1922	273·59	7,853	28·7	7,266	26·6	8,086	29·5	15,082	55·1
	1923	**280·56**	**7,822**	**27·9**	**8,272**	**29·5**	**7,396**	**26·4**	**14,339**	**51·1**
B ...	1921	172·18	8,581	49·8	4,746	27·6	8,121	47·2	10,025	58·2
	1922	181·85	6,885	37·8	4,163	22·9	7,533	41·4	10,381	57·1
	1923	**189·50**	**7,100**	**37·5**	**4,695**	**24·8**	**6,462**	**34·1**	**10,827**	**57·1**
C ...	1921	317·00	13,429	42·4	7,462	23·5	18,016	56·8	19,760	62·3
	1922	297.00	11,056	37·2	5,626	18·9	11,945	40·2	19,263	64·9
	1923	**314·00**	**11,697**	**37·3**	**8,884**	**28·3**	**12,710**	**40·5**	**19,480**	**62·0**
D ...	1921	178·80	7,429	41·5	3,527	19·8	6,992	39·1	11,712	65·5
	1922	180·80	6,106	33·8	4,924	27·2	5,693	31·5	12,197	67·5
	1923	**181·70**	**6,306**	**34·7**	**5,216**	**28·7**	**5,742**	**31·6**	**12,332**	**67·9**
E ...	1921	335·00	13,329	39·8	9,453	28·2	11,313	33·8	11,769	35·1
	1922	341·00	11,544	33·8	8,572	25·1	8,312	24·4	12,165	35·7
	1923	**351·00**	**13,157**	**37·5**	**9,936**	**28·3**	**8,955**	**25·5**	**12,733**	**36·3**
F ...	1921	204·00	9,407	46·1	7,174	35·2	7,754	38·0	8,833	43·3
	1922	210·00	6,560	31·2	4,953	23·6	6,012	28·6	8,801	41·9
	1923	**234·00**	**7,839**	**33·5**	**7,111**	**30·4**	**7,953**	**34·0**	**9,714**	**41·5**
G ...	1921	269·00	10,275	38·2	5,798	21·5	11,133	41·4	16,354	60·8
	1922	275·60	8,510	30·9	5,728	20·8	10,498	38·1	17,287	62·7
	1923	**287·70**	**9,383**	**32·6**	**6,247**	**21·7**	**10,974**	**38·1**	**18,020**	**62·6**
H ...	1921	232·29	8,639	37·2	5,869	25·3	7,098	30·6	14,969	64·4
	1922	239·15	6,597	27·6	5,268	22·0	5,457	22·8	15,223	63·7
	1923	**241·88**	**6,654**	**27·5**	**5,167**	**21·4**	**5,706**	**23·6**	**14,643**	**60·5**
I ...	1921	529·00	23,407	44·2	8,262	15·6	18,519	35·0	37,610	71·1
	1922	524·46	19,612	37·4	7,379	14.0	20,077	38·3	38,121	72·7
	1923	**541·00**	**20,415**	**37·7**	**7,049**	**13·0**	**15,782**	**29·2**	**39,571**	**73·1**
J ...	1921	429·00	17,049	39·7	16,870	39·3	19,579	45·6	26,992	62·9
	1922	445·00	14,000	31·5	15,035	33·8	18,258	41·0	28,841	64·8
	1923	**461·00**	**13,672**	**29·7**	**16,252**	**35·3**	**15,995**	**34·7**	**30,008**	**65·1**
K ...	1921	512·60	18,967	37·0	13,864	27·1	16,783	32·7	47,503	92·7
	1922	525·40	15,567	29·6	11,278	21·5	14,063	26·8	44,631	84·9
	1923	**537·40**	**14,356**	**26·7**	**10,629**	**19·8**	**13,501**	**25·1**	**43,748**	**81·4**
L ...	1921	174·00	7,180	41·3	4,547	26·1	7,210	41·4	10,557	60·7
	1922	176·00	7,334	41·7	4,546	25·8	7,067	40·2	14,257	81·0
	1923	**169·00**	**6,923**	**40·9**	**4,177**	**24·7**	**5,853**	**34·6**	**13,710**	**81·1**
M ...	1921	163·00	8,259	50·6	4,091	25·1	4,789	29·4	6,501	39·9
	1922	168·00	6,355	37·8	3,627	21·6	4,414	26·3	7,027	41·8
	1923	**179·00**	**5,924**	**33·1**	**3,301**	**18·4**	**4,296**	**24·0**	**6,601**	**36·9**
N* ...	**1923**	**318·60**	**9,884**	**29·1**	**7,051**	**20·8**	**8,869**	**26·1**	**18,674**	**55·0**
Total	1921	3,775·87	£156,142	£41·4	£99,510	£26·4	£147,007	£38·9	£237,269	£62·8
	1922	3,837·85	127,979	33·3	88,365	23·0	127,415	33·5	243,276	63·4
	1923	**4,286·34**	**141,132**	**32·9**	**103,987**	**24·3**	**130,194**	**30·4**	**264,400**	**61·7**

* Recognised as a Medical School during 1923.

EXPENDITURE PER OCCUPIED BED IN HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN ENGLAND AND WALES.



Illustrating Table 31.

TABLE 32.

EXPENDITURE ON FUEL AND LIGHT.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Coal and Coke.		Gas and Electricity.		Total. Fuel and Light.	
				Total.	Per available bed.	Total.	Per available bed.	Total.	Per available bed.
Group A	1921	90	17,727	£206,996	£11·68	£93,022	£5·24	£300,018	£16·92
	1922	105	20,459	190,483	9·31	104,336	5·10	294,819	14·41
	1923	**110**	**21,445**	**176,867**	**8·25**	**95,347**	**4·44**	**272,214**	**12·69**
Group B	1921	116	6,346	47,187	7·43	33,494	5·28	80,681	12·71
	1922	120	6,472	43,309	6.69	34,190	5·28	77,499	11·97
	1923	**136**	**7,138**	**42,843**	**6·00**	**33,143**	**4·64**	**75,986**	**10·64**
Group C	1921	173	2,495	16,639	6·67	11,840	4·74	28,479	11·41
	1922	167	2,452	14,989	6·11	11,061	4·51	26,050	10·62
	1923	**184**	**2,806**	**15,377**	**5·48**	**12,072**	**4·30**	**27,449**	**9·78**
Total	1921	379 = 65% (*a*)	26,568 = 79·65% (*b*)	£270,822	£10·19	£138,356	£5·21	£409,178	£15·40
	1922	392 = 67% (*a*)	29,383 = 86·50% (*b*)	248,781	8·47	149,587	5·09	398,368	13·56
	1923	**430 = 69% (*a*)**	**31,389 = 87·00% (*b*)**	**235,087**	**7·49**	**140,562**	**4·48**	**375,649**	**11·97**

(*a*) Percentage of Hospitals reviewed.
(*b*) Percentage of total available beds in Hospitals reviewed.

SECTION 6.

VOLUME OF WORK DONE IN THE VOLUNTARY HOSPITALS IN SCOTLAND.

If the larger number of Hospitals reviewed is taken into account, the volume of work done in the Scottish Hospitals during 1923 does not appear to have increased to any marked extent. The percentage of occupation of the beds available, especially in Groups A and B, is very much higher than in the corresponding English groups, and it might be inferred that the pressure was therefore correspondingly greater. It is possible, however, that the Scottish Hospitals are more conservative than the English in altering the number of their available beds, and that it is in reality higher than the official figures show. That there is some ground for this surmise is shown in the Table where figures of the "available beds" and the "percentage occupation" in the six Hospitals associated with Medical Schools are shown. In one only of these six is the percentage occupation below 92 per cent. and in two of the remaining five it exceeds 108 per cent. Occupation above the normal is, of course, of common occurrence in most Hospitals, but where it continues year after year it can only mean that there are beds really and normally available, even if they have not been officially recognised. That this is so in the five Hospitals referred to is borne out to some extent by the figures showing the average length of stay of the patients, which are higher than in the corresponding English group. Abnormal pressure as shown by average occupation might be expected to have a tendency to reduce the length of stay. This, however, and many other points of interest, will no doubt be brought out in the Survey which it is understood is now being made of the Voluntary Hospitals in Scotland. In the English Tables reference was made to the large amount of out-patient work undertaken in the Special Hospitals in the C group. It is even more noticeable in the corresponding C group in Scotland. Four of these eight have beds, it is true, but the out-patient work is very large compared with the In-patient. Incidentally this fact brings out the imperfection of the bed basis for the purposes of comparison, whether in the matter of cost or of work done.

TABLE 33.

NUMBER OF IN-PATIENTS AND OUT-PATIENTS TREATED AND PERCENTAGE OF AVAILABLE BEDS OCCUPIED.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Percentage of available beds occupied daily.	No. of New In-patients.	No. of New Out-patients.
Group A	1920	18	4,918	92·39%	71,939	240,701
	1921	17	5,163	87·36%	71,172	227,048
	1922	18	5,316	87·28%	78,143	250,327
	1923	**19**	**5,435**	**90·81%**	**82,822**	**257,700**
Group B	1920	20	1,101	80·86%	14,019	36,671
	1921	20	1,142	77·59%	12,716	35,827
	1922	19	1,122	83·57%	14,074	35,711
	1923	**20**	**1,149**	**86·53%**	**14,728**	**36,894**
Group C	1920	37	539	77·16%	5,807	32,060
	1921	36	550	72·75%	6,516	22,632
	1922	35	537	61·16%	6,692	25,534
	1923	**46**	**728**	**63·32%**	**7,544**	**30,590**
Total	1920	75=96% (*a*)	6,558=99% (*b*)		91,765	309,432
	1921	73=97% (*a*)	6,855=99% (*b*)		90,404	285,507
	1922	72=91% (*a*)	6,975=99% (*b*)		98,909	311,572
	1923	**85=99% (*a*)**	**7,312=99% (*b*)**		**105,094**	**325,184**

(*a*) Percentage of Hospitals reviewed.
(*b*) Percentage of beds in Hospitals reviewed.

TABLE 34.

NUMBER OF PATIENTS TREATED IN GENERAL AND SPECIAL HOSPITALS DURING 1923 SHOWN SEPARATELY.

Hospitals.	No. of Hospitals giving details.	No. of available beds.	No. of New In-patients.	No. of New Out-patients.
General Hospitals—				
Group A	15	4,775	68,410	199,377
Group B	12	624	7,172	13,620
Group C	38	600	5,490	2,522
Total of General Hospitals	65	5,999	81,072	215,519
Special Hospitals—				
Group A	4	660	14,412	58,323
Group B	8	525	7,556	23,274
Group C	8	128	2,054	28,068
Total of Special Hospitals	20	1,313	24,022	109,665

TABLE 35.

NUMBER OF SURGICAL OPERATIONS UNDER GENERAL ANAESTHETIC.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	No. of operations.
Group A	1921	17	5,163	42,769
	1922	18	5,316	53,523
	1923	**19**	**5,435**	**59,064**
Group B	1921	14	819	8,566
	1922	13	779	9,094
	1923	**16**	**889**	**9,717**
Group C	1921	26	390	5,815
	1922	28	399	5,910
	1923	**38**	**591**	**7,549**
Total	1921	57=76% (*a*)	6,372=92·52% (*b*)	57,150
	1922	59=75% (*a*)	6,494=91·79% (*b*)	68,527
	1923	**73=85%** (*a*)	**6,915=94·39%** (*b*)	**76,330**

(*a*) Percentage of Hospitals reviewed.
(*b*) Percentage of beds in Hospitals reviewed.

TABLE 36.

SURVEY OF THE WORK DONE IN THE 6 HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

1	2	3	4	5	6	7	8	9	10
Hospital.	Year.	No. of available beds.	Average No. of beds occupied daily.	Percentage of available beds occupied.	No. of New In patients.	No. of In-patients per occupied bed.	Average length of stay per In-patient (days).	No. of New Out-patients.	No. of Surgical Operations.
A	1920	270	253·00	93·70	3,369	13·31	28·00	14,650	3,290
	1921	270	249·00	92·22	3,554	14·31	25·00	15,246	3,403
	1922	270	269·00	99·63	3,687	13·71	25·00	14,401	3,139
	1923	**304**	**285·00**	**93·75**	**3,896**	**13·67**	**25·00**	**15,577**	**3,586**
B	1920*	400	342·00	85·50	5,441	15·91	23·90	17,952	3,767
	1921*	414	326·00	78·74	4,610	14·14	23·20	17,737	3,795
	1922*	414	332·33	80·27	5,588	16·81	21·68	14,804	—
	1923	**422**	**333·36**	**79·00**	**5,816**	**17·45**	**20·71**	**15,365**	**4,979**
C	1920	963	875·00	90·86	12,521	14·31	24·05	48,117	—
	1921	963	869·00	90·24	12,814	14·74	22·20	41,859	6,765
	1922	963	876·00	90·97	13,372	15·26	22·10	42,342	6,582
	1923	**963**	**897·00**	**93·15**	**14,231**	**15·84**	**21·30**	**46,693**	**6,840**
D	1920	665	680·80	102·37	10,474	15·38	22·40	40,522	8,733
	1921	665	680·20	102·29	10,155	14·93	23·00	41,857	8,843
	1922	665	657·90	98·93	10,809	16·43	21·10	44,689	8,613
	1923	**665**	**722·90**	**108·72**	**12,106**	**16·75**	**20·70**	**48,693**	**10,062**
E	1920	600	587·00	97·83	8,938	15·23	22·37	26,871	—
	1921	600	557·00	92·83	8,988	16·14	21·25	26,129	5,029
	1922	600	555·00	92·50	10,766	19·40	20·81	35,167	6,126
	1923	**600**	**554·00**	**92·33**	**9,444**	**17·05**	**20·29**	**32,450**	**5,600**
F	1920	260	271·00	104·23	3,971	14·65	25·20	10,423	2,153
	1921	260	283·00	108·85	4,082	14·42	25·00	12,132	2,150
	1922	260	286·00	110·00	3,950	13·81	25·90	9,881	2,025
	1923	**260**	**288·00**	**110·77**	**4,223**	**14·66**	**24·40**	**11,843**	**1,987**
Total ...	1920	3,158	3,008·80	95·28	44,714	14·86		158,535	
	1921	3,172	2,964·20	93·45	44,203	14·91		154,960	
	1922	3,172	2,976·23	93·83	48,172	16·19		161,284	
	1923	**3,214**	**3,080·26**	**95·84**	**49,716**	**16·14**		**170,621**	

* Year ended 15th May.

SECTION 7.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

During the four year period 1920 to 1923 inclusive, the Scottish Hospitals have received each year an average of approximately £1,229,000, and have spent an average of approximately £926,000. As the Total Receipts for 1923 exceed the average by approximately £75,000, and the Total Expenditure does not exceed the average by more than £1,271, any alarm with regard to the financial stability of the Voluntary System, in Scotland at all events, appears to be groundless. It is true that there are seven more Hospitals included in the 1923 figures than in those of 1922. As, however, the Total Receipts and Total Expenditure of these seven Hospitals amounted to only £13,435 and £9,054 respectively, the increase in the number of Hospitals influences the general relationship of receipts to expenditure, or the relationship of the 1923 figures to those of the preceding year, very slightly.

It is even more satisfactory to find, as we do from Tables 38 and 39, that each group shares in this excess of Total Receipts, and that 88 per cent. of the Scotch Hospitals had balances on the credit side. Four years ago the figure was 73 per cent. In the A Group there was only one Hospital that ended the year with an adverse balance amounting to £7,436; two in the B Group totalling £808; and seven in the C Group totalling £2,122. Table 40 shows that while the position of the General Hospitals is financially strong, that of the Special Hospitals is still stronger. On the available bed basis the General Hospitals had a surplus of £43 per bed, whereas the Special had a surplus of £87.

TABLE 37.

TOTAL RECEIPTS AND TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	18	£976,198	£750,033	£226,165
	1921	17	884,613	769,158	115,455
	1922	18	942,144	677,291	264,853
	1923	**19**	**951,586**	**720,890**	**230,696**
Group B	1920	21	182,507	131,714	50,793
	1921	20	172,835	126,722	46,113
	1922	20	197,191	126,347	70,844
	1923	**20**	**220,029**	**132,176**	**87,853**
Group C	1920	39	92,386	64,273	28,113
	1921	38	84,371	66,350	18,021
	1922	41	80,735	65,205	15,530
	1923	**47**	**132,672**	**74,327**	**58,345**
Total	1920	78	£1,251,091	£946,020	£305,071
	1921	75	1,141,819	962,230	179,589
	1922	79	1,220,070	868,843	351,227
	1923	**86**	**1,304,287**	**927,393**	**376,894**

TABLE 38.

HOSPITALS HAVING AN **EXCESS OF TOTAL RECEIPTS** OVER TOTAL EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Surplus.
Group A	1920	15 (83%)	£914,358	£674,914	£239,444
	1921	12 (71%)	752,920	606,677	146,243
	1922	13 (72%)	855,479	581,049	274,430
	1923	**18 (95%)**	**938,274**	**700,142**	**238,132**
Group B	1920	14 (67%)	147,307	92,297	55,010
	1921	16 (80%)	155,835	106,903	48,932
	1922	18 (90%)	185,903	114,539	71,364
	1923	**18 (90%)**	**212,436**	**123,775**	**88,661**
Group C	1920	28 (72%)	77,001	44,151	32,850
	1921	27 (71%)	63,568	39,010	24,558
	1922	32 (78%)	66,545	45,850	20,695
	1923	**40 (85%)**	**122,839**	**62,372**	**60,467**
Total	1920	57 (73%)	£1,138,666	£811,362	£327,304
	1921	55 (73%)	972,323	752,590	219,733
	1922	63 (80%)	1,107,927	741,438	366,489
	1923	**76 (88%)**	**1,273,549**	**886,289**	**387,260**

TABLE 39.

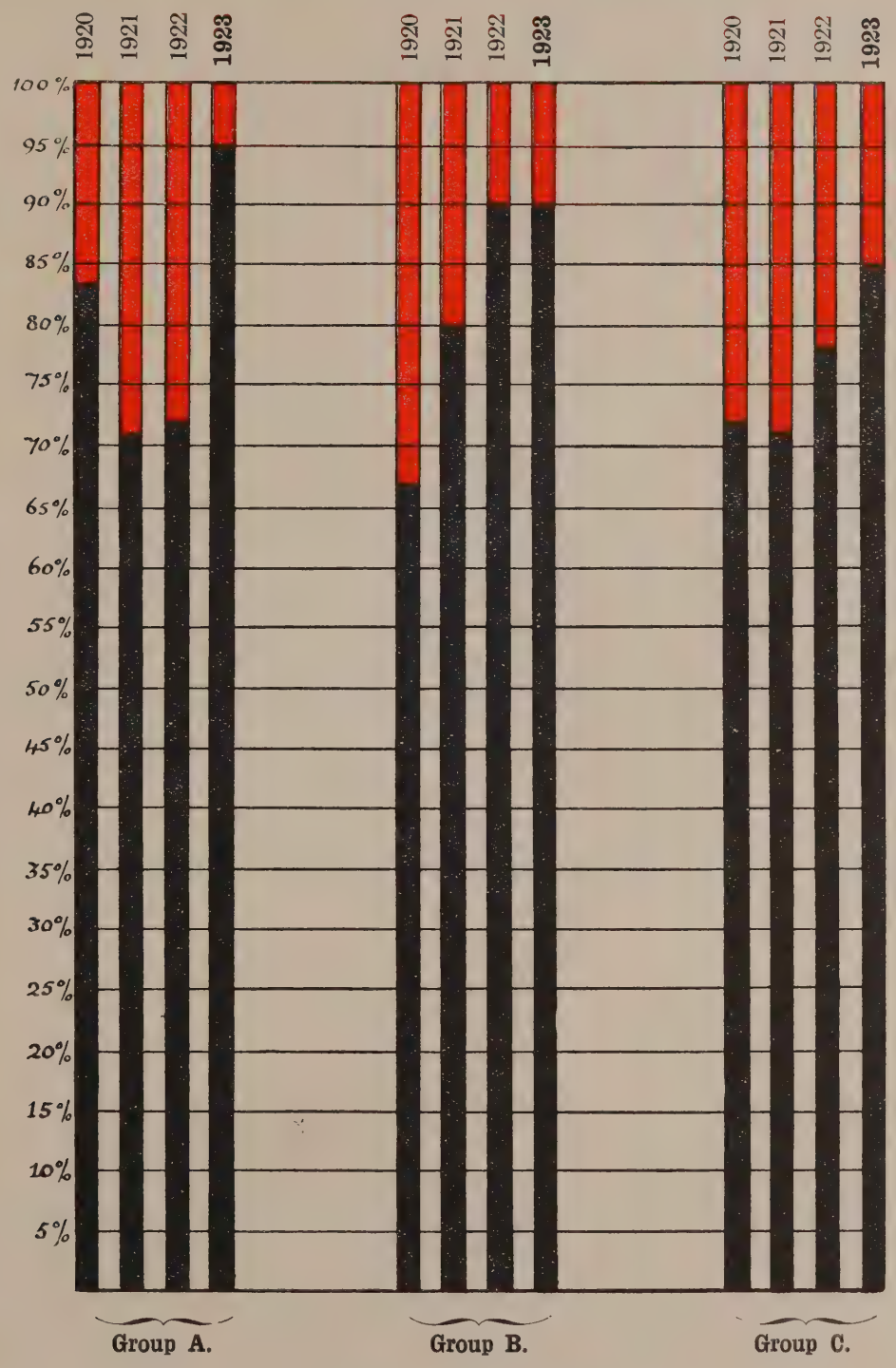
HOSPITALS HAVING AN **EXCESS OF TOTAL EXPENDITURE** OVER TOTAL RECEIPTS.

Hospitals.	Year.	No. of Hospitals.	Total Receipts.	Total Expenditure.	Deficit.
Group A	1920	3 (17%)	£61,840	£75,119	£13,279
	1921	5 (29%)	131,693	162,481	30,788
	1922	5 (28%)	86,665	96,242	9,577
	1923	**1 (5%)**	**13,312**	**20,748**	**7,436**
Group B	1920	7 (33)%	35,200	39,417	4,217
	1921	4 (20%)	17,000	19,819	2,819
	1922	2 (10%)	11,288	11,808	520
	1923	**2 (10%)**	**7,593**	**8,401**	**808**
Group C	1920	11 (28%)	15,385	20,122	4,737
	1921	11 (29%)	20,803	27,340	6,537
	1922	9 (22%)	14,190	19,355	5,165
	1923	**7 (15%)**	**9,833**	**11,955**	**2,122**
Total	1920	21 (27%)	£112,425	£134,658	£22,233
	1921	20 (27%)	169,496	209,640	40,144
	1922	16 (20%)	112,143	127,405	15,262
	1923	**10 (12%)**	**30,738**	**41,104**	**10,366**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—

TOTAL RECEIPTS ... ... Shown in Black.

TOTAL EXPENDITURE ... Shown in Red.



Illustrating Tables 38 *and* 39.

TABLE 40.

TOTAL RECEIPTS AND TOTAL EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hosps.	Available beds.	Total Receipts.	Total Expenditure.	Surplus.
General Hospitals:					
Group A	15	4,775	£818,951	£623,719	£195,232
Group B	12	624	88,141	54,994	33,147
Group C	39	614	94,196	60,427	33,769
Total	**66**	**6,013**	**£1,001,288**	**£739,140**	**£262,148**
Special Hospitals:					
Group A	4	660	£132,635	£97,171	£35,464
Group B	8	525	131,888	77,182	54,706
Group C	8	128	38,476	13,900	24,576
Total	**20**	**1,313**	**£302,999**	**£188,253**	**£114,746**

SECTION 8.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

Taken as they stand, and without reference to the figures of Total Receipts and Total Expenditure, the figures of Ordinary Income and Ordinary Expenditure would give rise to a certain amount of doubt as to the financial position of the Scottish Hospitals, especially those in the A Group. Table 42 shows that only one Hospital in Group A had a surplus of Ordinary Income, and although the position in the B and C Groups is considerably better, yet in each there is a percentage of Hospitals (20 per cent. and 23 per cent. respectively) in which Ordinary Income failed to meet Ordinary Expenditure. This apparently unsatisfactory position is, however, almost entirely discounted by the free legacies which form year by year so large a portion of the receipts of the Scottish Hospitals. Indeed, their receipt is so regular that to call them "extraordinary" is a mere matter of nomenclature. Out of the 19 Hospitals in the A Group, 13 received free legacies totalling £217,991, available and more than sufficient in every case to meet deficits in their maintenance accounts aggregating £62,718; five had free legacies of £11,770 towards the reduction of deficits of £20,602, and one had a surplus on maintenance account irrespective altogether of free legacies.

Tables 44, 45 and 46 give the figures of Ordinary Income and Ordinary Expenditure reduced to the basis of the available bed. With all its imperfection this basis enables one to form some idea of the tendency of Income and Expenditure year by year. In the A group the tendency of Income and of Expenditure is to fall, in the B Group for Income to rise and for Expenditure to fall, in the C group for Income to remain stationary and for Expenditure to fall. In the Hospitals as a whole there is a tendency for both Income and Expenditure to fall. It is interesting to contrast the English and the Scottish Hospitals in this respect, for while in the case of the English Hospitals there is a similar downward tendency in Expenditure, there is a marked upward tendency in Income. There are also other striking contrasts. In the English Hospitals the A group is the best off in the matter of Income per bed; in Scotland the A group is the worst off. In the English Hospitals a deficit of Ordinary Income per available bed amounting to £15 in 1920 has been converted into a surplus of £7. In Scotland, the deficit of £12 in 1920 has been reduced to a deficit of £8. In this connection it is useful to show side by side the amounts received in 1923 from six similar sources of Ordinary Income in each country.

	England.	*Scotland.*
Amount received per available bed from Interest on Investments	£ 18·95	£ 24·91
,, ,, ,, ,, ,, ,, Workmen's Contributions	30·28	22·42
,, ,, ,, ,, ,, ,, Patients' Contributions	16·67	6·85
,, ,, ,, ,, ,, ,, Public Services	13·69	7·73
,, ,, ,, ,, ,, ,, Subscriptions	16·93	19·20
,, ,, ,, ,, ,, ,, Donations	23·17	15·86
	£ 119·70	£ 96·97

This Table shows that in Scotland more reliance is placed on the older form of support—Legacies and Subscriptions; in England, upon the newer—Workmen's Contributions, Patients' Payments, and Public Services.

The figures of Income under the above headings will grow more interesting each year, indicating possibly, to some extent at least, a certain difference in Hospital policy.

TABLE 41.

ORDINARY INCOME AND EXPENDITURE.

Hospitals.	Year.	No. of Hosps.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.	Surplus.
Group A	1920	18	£612,884	£689,094	£76,210	—
	1921	17	605,120	672,927	67,807	—
	1922	18	563,302	631,437	68,135	—
	1923	**19**	**561,243**	**644,420**	**83,177**	—
Group B	1920	21	124,122	125,864	1,742	—
	1921	20	117,946	121,018	3,072	—
	1922	20	123,507	114,259	—	£9,248
	1923	**20**	**127,451**	**111,096**	—	**16,355**
Group C	1920	39	56,982	57,188	206	—
	1921	38	62,804	61,134	—	1,670
	1922	41	63,657	58,981	—	4,676
	1923	**47**	**76,853**	**66,049**	—	**10,804**
Total...	1920	78	£793,988	£872,146	£78,158	—
	1921	75	785,870	855,079	69,209	—
	1922	79	750,466	804,677	54,211	—
	1923	**86**	**765,547**	**821,565**	**56,018**	—

TABLE 42.

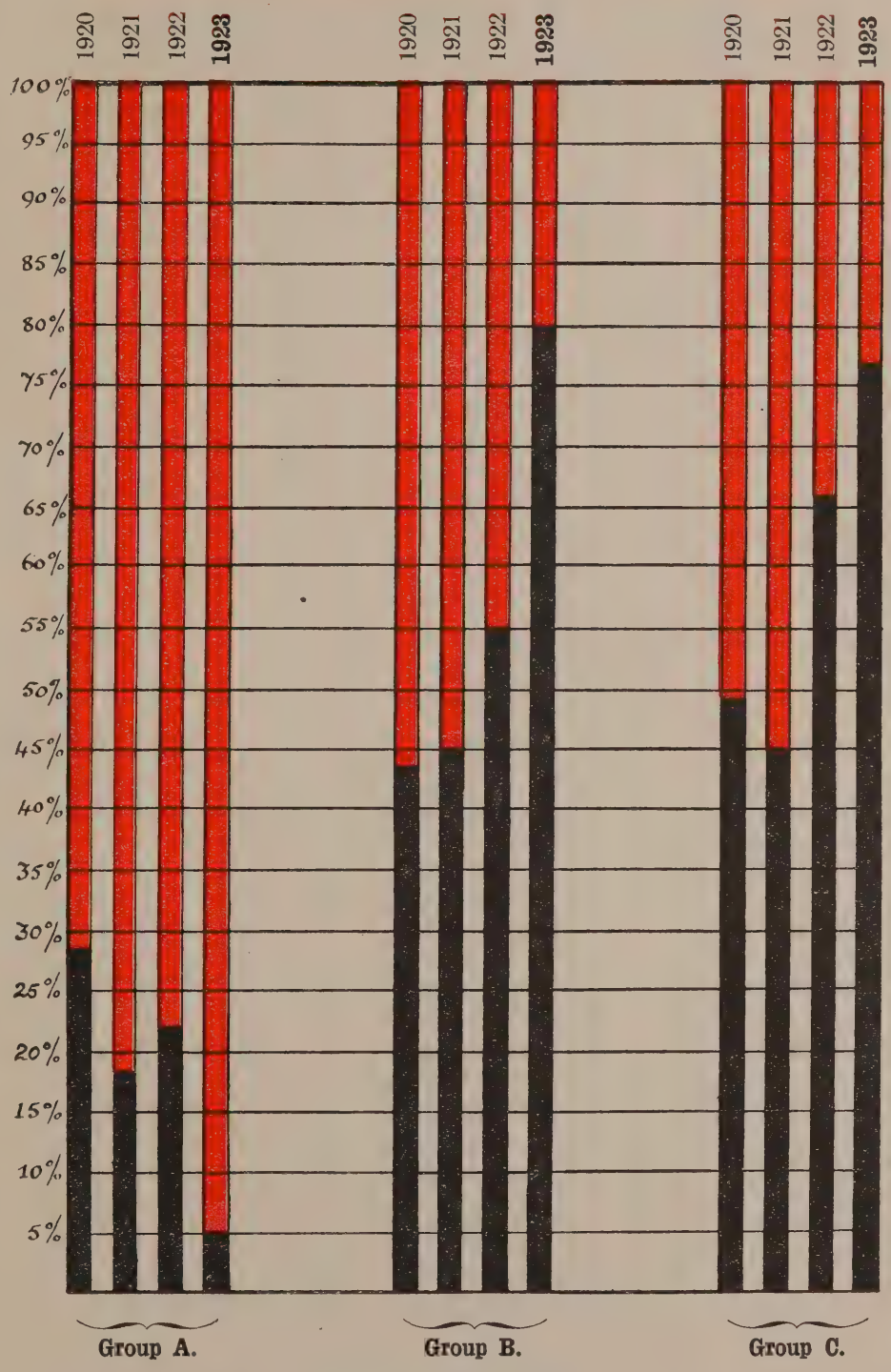
HOSPITALS HAVING AN **EXCESS OF ORDINARY INCOME** OVER ORDINARY EXPENDITURE.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary. Expenditure.	Surplus.
Group A	1920	5 (28%)	£99,682	£78,118	£21,564
	1921	3 (18%)	103,883	88,551	15,332
	1922	4 (22%)	55,661	50,538	5,123
	1923	**1** (5%)	**5,775**	**5,632**	**143**
Group B	1920	9 (43%)	64,910	51,051	13,463
	1921	9 (45%)	57,142	49,051	8,091
	1922	11 (55%)	73,130	58,821	14,309
	1923	**16 (80%)**	**106,739**	**87,863**	**18,876**
Group C	1920	19 (49%)	27,329	22,515	4,814
	1921	17 (45%)	33,214	24,952	8,262
	1922	27 (66%)	40,886	33,058	7,828
	1923	**36 (77%)**	**63,129**	**49,802**	**13,327**
Total	1920	33 (42%)	£191,921	£152,080	£39,841
	1921	29 (39%)	194,239	162,554	31,685
	1922	42 (53%)	169,677	142,417	27,260
	1923	**53 (62%)**	**175,643**	**143,297**	**32,346**

PERCENTAGE OF HOSPITALS HAVING AN EXCESS OF:—

ORDINARY INCOME ... ... Shown in Black.

ORDINARY EXPENDITURE ... Shown in Red.



Illustrating Tables 42 and 43.

TABLE 43.

HOSPITALS HAVING AN **EXCESS OF ORDINARY EXPENDITURE** OVER ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Total Ordinary Income.	Total Ordinary Expenditure.	Deficit.
Group A	1920	13 (72%)	£513,202	£610,976	£97,774
	1921	14 (82%)	501,237	584,376	83,139
	1922	14 (78%)	507,641	580,899	73,258
	1923	**18 (95%)**	**555,468**	**638,788**	**83,320**
Group B	1920	12 (57%)	59,212	74,417	15,205
	1921	11 (55%)	60,804	71,967	11,163
	1922	9 (45%)	50,377	55,438	5,061
	1923	**4 (20%)**	**20,712**	**23,233**	**2,521**
Group C	1920	20 (51%)	29,653	34,673	5,020
	1921	21 (55%)	29,590	36,182	6,592
	1922	14 (34%)	22,771	25,923	3,152
	1923	**11 (23%)**	**13,724**	**16,247**	**2,523**
Total	1920	45 (58%)	£602,067	£720,066	£117,999
	1921	46 (61%)	591,631	692,525	100,894
	1922	37 (47%)	580,789	662,260	81,471
	1923	**33 (38%)**	**589,904**	**678,268**	**88,364**

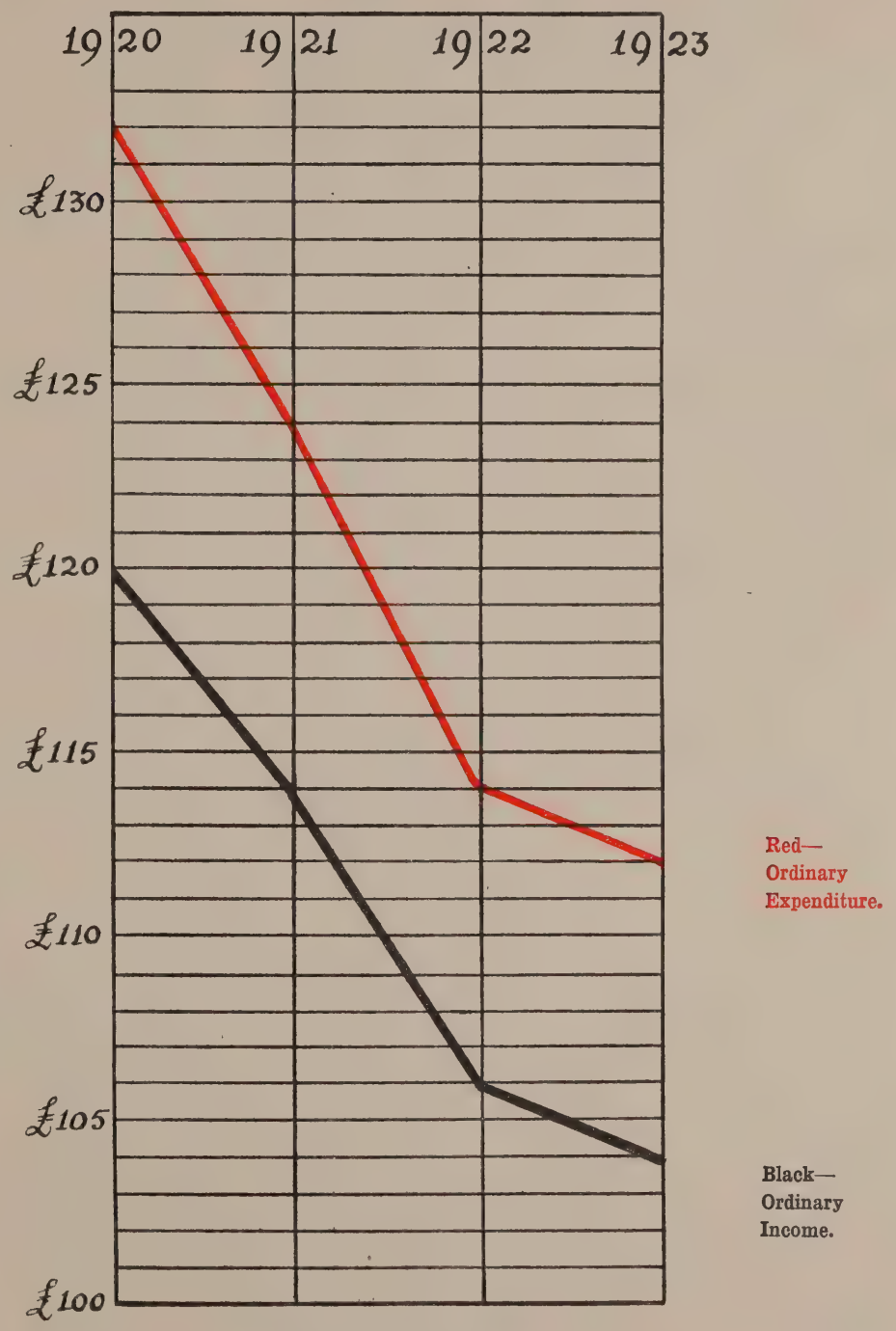
TABLE 44.

SURPLUS OR DEFICIT BETWEEN ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED.

Hospitals.	Year.	No. of Hosps.	No. of available beds.	Ordinary Income per available bed.	Ordinary Expenditure per available bed.	Surplus (+) or Deficit (—).
Group A	1920	18	4,918	£125*	£140*	— £15*
	1921	17	5,163	117	130	— 13
	1922	18	5,316	106	119	— 13
	1923	**19**	**5,435**	**103**	**119**	**— 16**
Group B	1920	21	1,136	109	112	— 3
	1921	20	1,142	103	106	— 3
	1922	20	1,152	107	99	+ 8
	1923	**20**	**1,149**	**111**	**97**	**+ 14**
Group C	1920	39	552	103	104	— 1
	1921	38	582	108	105	+ 3
	1922	41	607	105	97	+ 8
	1923	**47**	**742**	**104**	**89**	**+ 15**
Total	1920	78	6,606	£120	£132	—£12
	1921	75	6,887	114	124	— 10
	1922	79	7,075	106	114	— 8
	1923	**86**	**7,326**	**104**	**112**	**— 8**

* Calculated to the nearest £.

ORDINARY INCOME AND ORDINARY EXPENDITURE PER AVAILABLE BED OF THE TOTAL NUMBER OF HOSPITALS REVIEWED.



Illustrating Table 44.

TABLE 45.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF GENERAL AND SPECIAL HOSPITALS SHOWN SEPARATELY.

Hospitals.	No. of Hosps.	Available beds.	Ordinary Income.		Ordinary Expenditure.		Surplus (+) or Deficit (—) per available bed.
			Total.	Per available bed.	Total.	Per available bed.	
General Hospitals—							
Group A	15	4,775	£484,501	£102	£552,632	£116	— £14
Group B	12	624	58,460	94	51,669	83	+ 11
Group C	39	614	58,076	95	52,223	85	+ 10
Total	66	6,013	£601,037	£100	£656,524	£109	— £ 9
Special Hospitals—							
Group A	4	660	£76,742	£116	£91,788	£139	— £23
Group B	8	525	68,991	131	59,427	113	+ 18
Group C	8	128	18,777	147	13,826	108	+ 39
Total	20	1,313	£164,510	£125	£165,041	£126	— £ 1

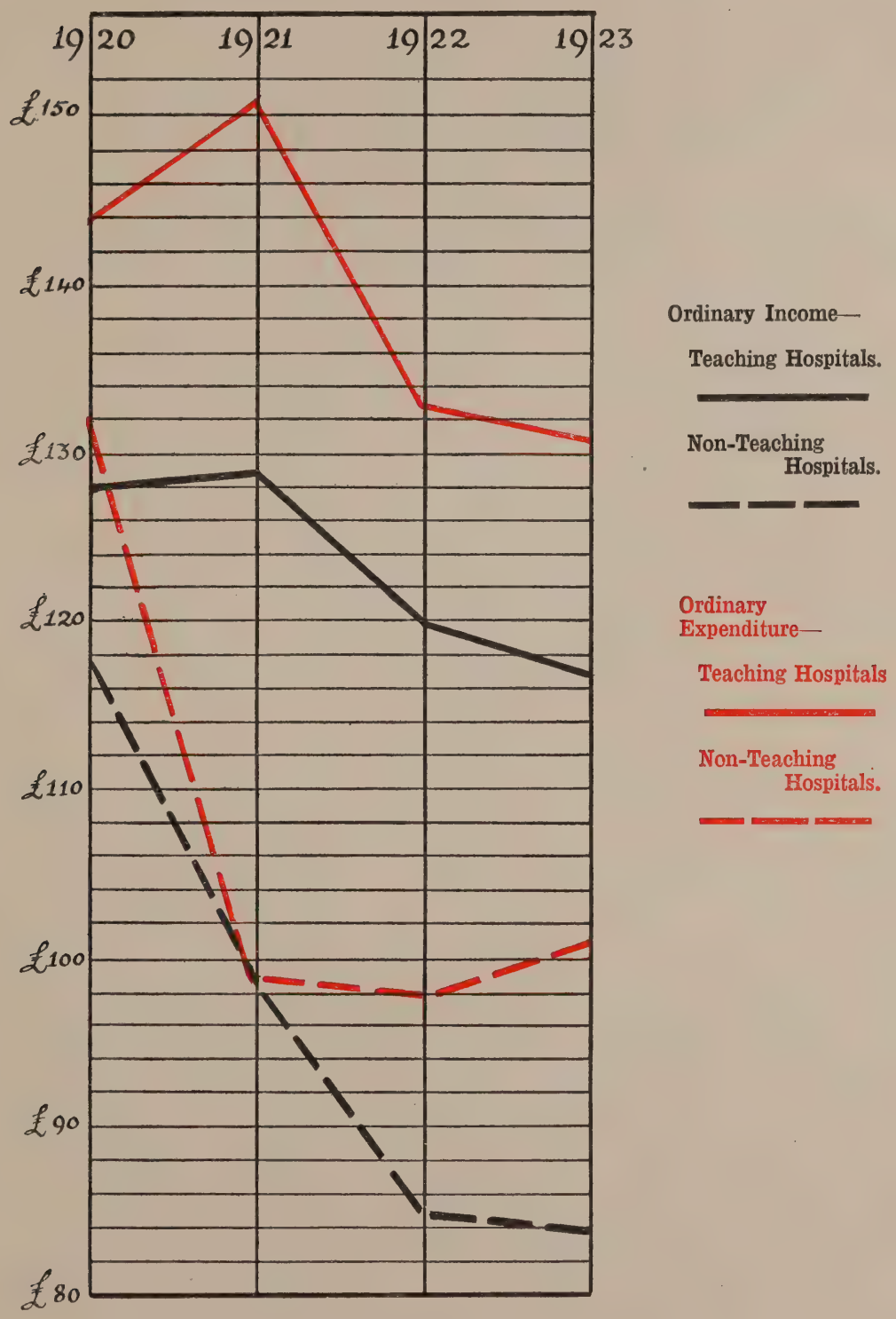
TABLE 46.

ORDINARY INCOME AND ORDINARY EXPENDITURE OF THE TEACHING AND NON-TEACHING HOSPITALS IN GROUP A IN SCOTLAND SHOWN SEPARATELY.

Hospitals.	Year.	No. of Hospitals.	No. of available beds.	Ordinary Income.		Ordinary Expenditure.		Deficit per available bed.
				Total.	Per available bed.	Total.	Per available bed.	
Medical School Hospitals	1920	6	3,193	£408,875	£128*	£460,628	£144*	£16*
	1921	6	3,172	410,478	129	479,602	151	22
	1922	6	3,172	381,593	120	422,355	133	13
	1923	**6**	**3,214**	**375,620**	**117**	**420,683**	**131**	**14**
Non-Teaching Hospitals	1920	12	1,725	204,009	118	228,466	132	14
	1921	11	1,956	194,642	99	193,325	99	—
	1922	12	2,144	181,709	85	209,082	98	13
	1923	**13**	**2,221**	**185,623**	**84**	**223,737**	**101**	**17**

* Calculated to the nearest £.

ORDINARY INCOME AND EXPENDITURE PER AVAILABLE BED OF HOSPITALS CONSTITUTING GROUP A.



Illustrating Table 46.

TABLE 47.

ORDINARY INCOME AND EXPENDITURE OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Ordinary Income.	Ordinary Expenditure.	Ordinary Income per *occupied* bed.	Ordinary Expenditure per *occupied* bed.	Deficit (—) or Surplus (+) per *occupied* bed.
A	1920	£31,401	£33,388	£124·11	£131·96	£7·85 (—)
	1921	31,013	32,464	124·55	130·38	5·83 (—)
	1922	27,130	29,572	100·85	109·93	9·08 (—)
	1923	**28,404**	**29,963**	**99·66**	**105·13**	**5·47** (—)
B	1920*	23,537	37,439	68·82	109·47	40·65 (—)
	1921*	34,632	42,631	106·23	130·77	24·54 (—)
	1922*	35,286	37,042	106·18	111·46	5·28 (—)
	1923	**26,852**	**36,291**	**80·55**	**108·86**	**28·31** (—)
C	1920	133,354	130,668	152·40	149·33	3·07 (+)
	1921	110,203	133,328	126·82	153·43	26·61 (—)
	1922	105,878	119,759	120·84	136·71	15·87 (—)
	1923	**116,509**	**119,810**	**129·89**	**133·57**	**3·68** (—)
D	1920	105,920	115,419	155·76	169·73	13·97 (—)
	1921	105,359	116,982	154·89	171·98	17·09 (—)
	1922	101,315	104,813	154·00	159·31	5·31 (—)
	1923	**94,176**	**107,598**	**130·28**	**148·84**	**18·56** (—)
E	1920	75,150	99,080	128·02	168·79	40·77 (—)
	1921	81,031	107,444	145·48	192·90	47·42 (—)
	1922	68,348	88,534	123·14	159·05	35·91 (—)
	1923	**68,418**	**84,352**	**123·50**	**152·26**	**28·76** (—)
F	1920	39,513	44,634	145·80	164·70	18·90 (—)
	1921	48,240	46,753	170·46	165·20	5·26 (+)
	1922	43,636	42,635	152·57	149·07	3·50 (+)
	1923	**41,261**	**42,669**	**143·27**	**148·16**	**4·89** (—)
Total	1920	£408,875	£460,628	£135·89	£153·09	£17·20 (—)
	1921	410,478	479,602	138·48	161·80	23·32 (—)
	1922	381,593	422,355	128·21	141·90	13·69 (—)
	1923	**375,620**	**420,683**	**121·94**	**136·57**	**14·63** (—)

* Year ended 15th May.

SECTION 9.

ANALYSIS OF SOME OF THE SOURCES OF ORDINARY INCOME OF THE VOLUNTARY HOSPITALS IN SCOTLAND.

INVESTED FUNDS.

Table 48 shows the distribution of Invested funds between the Groups A, B and C. Their growth is most marked in the B Group, where more than £200 per available bed has been added since 1920. Group C has now £648 invested for each of its available beds, and is comparatively the best endowed of the three.

WORKMEN'S CONTRIBUTIONS.

This source of income shows no tendency to increase in Scotland. As Table 49 shows, the figures per available bed for 1923 are below those of 1920 in each of the three groups. Trade depression has no doubt adversely affected contributions from this source.

PATIENTS' CONTRIBUTIONS.

Patients' Contributions have decreased per available bed in the Hospitals as a whole. There is a marked difference between the amounts raised in the B and C Groups as compared with the amount raised in the A Group. While the figures in the B and C Groups are considerably higher than those in the A Group, they are very much lower than those in the corresponding English B and C Groups. These two English groups are, of course, those in which beds for Paying Patients are most usually found. Possibly the same reason accounts for the higher figures in Scotland.

INCOME FROM PUBLIC SERVICES.

This source of income remains stationary approximately at £8 per available bed in the Hospitals as a whole. The graph, however, shows that if the payments by the War Office and the Ministry of Pensions are eliminated there is a very distinct upward tendency. Here, as in the English Hospitals, it is unfortunate that so large an amount—£19,899—has, for lack of information, to be placed under the heading " Details not given."

SUBSCRIPTIONS AND DONATIONS.

The figures per available bed of both Subscriptions and Donations in the Hospitals as a whole are slightly down for the year 1923 as compared with 1922, and both are lower than they were in 1920. There is, however, a marked improvement in " Donations " for 1923 in the B and C Groups.

Table 56 gives a summary of the analysis of Income from the above six sources. It shows that the A Group has improved its position in two ; the B Group in five ; and the C Group in three. In this Table there are in each group (excluding totals) 6 sets of figures or points at which comparisons between the year 1922 and 1923 can be made. If these points are examined it will be found that out of a total of 18 there are 10 where the 1923 figures show an improvement on those of 1922. It would not be reasonable to expect every year, and especially in these years of bad trade, Income from every source to increase. It is indeed surprising to find that, on the whole, so little ground has been lost.

TABLE 48.

INVESTED FUNDS AND THE INTEREST THEREFROM.

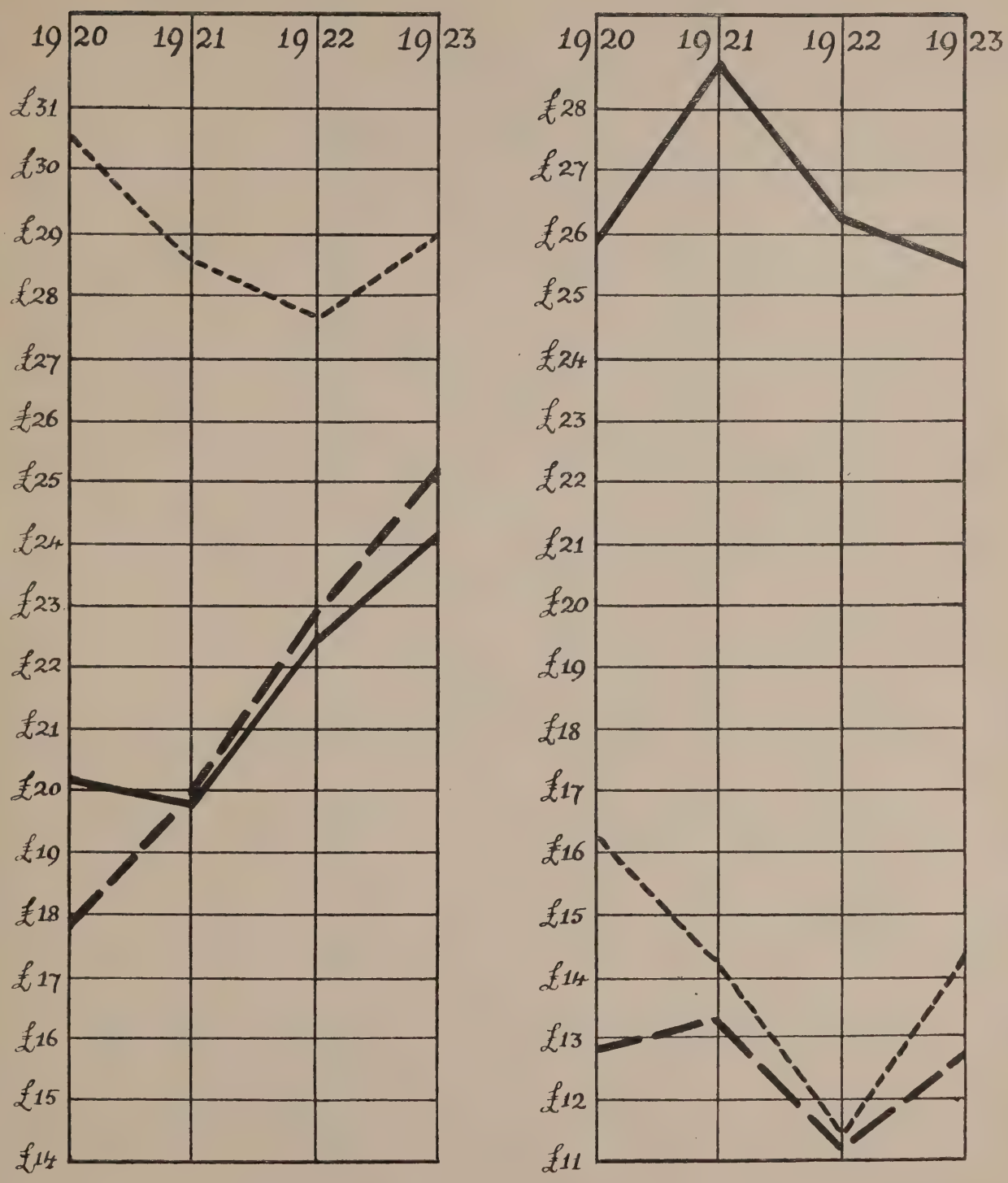
Hospitals.	Year.	No. of Hospitals.	Invested Funds.		Interest from Investments.	
			Total.	Per available bed.	Total	Amount per available bed.
Group A	1920	18	£2,112,671	£430	£99,362	£20·20
	1921	17	2,157,373	418	102,363	19·83
	1922	18	2,473,707	465	119,457	22·47
	1923	**19**	**2,720,189**	**500**	**131,625**	**24·22**
Group B	1920	21	425,004	374	20,410	17·97
	1921	20	506,331	443	22,847	20·01
	1922	20	547,392	475	26,532	23·03
	1923	**20**	**669,600**	**583**	**29,327**	**25·24**
Group C	1920	39	362,447	658	16,915	30·64
	1921	38	370,799	637	16,663	28·63
	1922	41	357,502	589	16,803	27·68
	1923	**47**	**480,613**	**648**	**21,551**	**29·04**
Total	1920	78	£2,900,122	£422	£136,687	£20·69
	1921	75	3,034,503	441	141,873	20·60
	1922	79	3,378,601	478	162,792	23·01
	1923	**86**	**3,870,402**	**528**	**182,503**	**24·91**

TABLE 49.

WORKMEN'S CONTRIBUTIONS, HOSPITAL SATURDAY FUNDS, AND CONTRIBUTORY SCHEMES.

Hospitals.	Year.	No. of Hospitals.	Total Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes.	Amount per available bed.
Group A	1920	18	£127,991	£26·02
	1921	17	148,658	28·79
	1922	18	139,845	26·31
	1923	**19**	**138,898**	**25·56**
Group B	1920	21	14,637	12·88
	1921	20	15,216	13·32
	1922	20	12,995	11·28
	1923	**20**	**14,643**	**12·74**
Group C	1920	39	9,006	16·32
	1921	38	8,285	14·24
	1922	41	6,973	11·49
	1923	**47**	**10,692**	**14·41**
Total	1920	78	£151,634	£22·95
	1921	75	172,159	25·00
	1922	79	159,813	22·59
	1923	**86**	**164,233**	**22·42**

AMOUNT PER AVAILABLE BED DERIVED FROM



Group A

Group B

Group C

Illustrating Tables 48 *and* 49.

TABLE 50.

PATIENTS' CONTRIBUTIONS (including donations from "Grateful Patients").

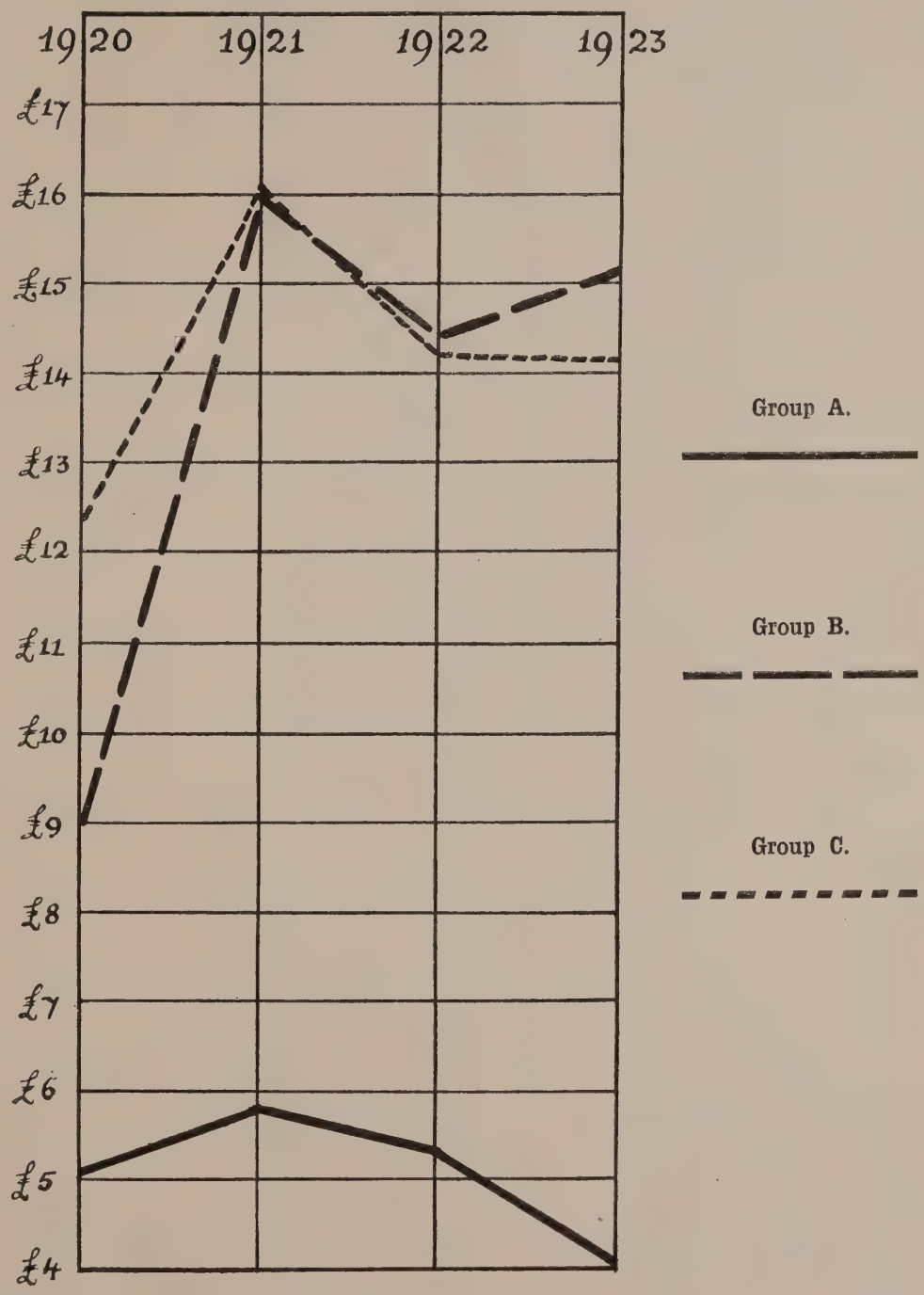
Hospitals.	Year.	No. of Hospitals.	Total Patients' Contributions.	Amount per available bed.
Group A	1920	18	£25,155	£5·11
	1921	17	30,215	5·85
	1922	18	28,468	5·36
	1923	**19**	**22,251**	**4·09**
Group B	1920	21	10,176	8·96
	1921	20	18,277	16·00
	1922	20	16,652	14·45
	1923	**20**	**17,417**	**15·16**
Group C	1920	39	6,842	12·39
	1921	38	9,328	16·03
	1922	41	8,648	14·25
	1923	**47**	**10,501**	**14·15**
Total	1920	78	£42,173	£6·38
	1921	75	57,820	8·40
	1922	79	53,768	7·60
	1923	**86**	**50,169**	**6·85**

TABLE 51.

INCOME FROM PUBLIC SERVICES.

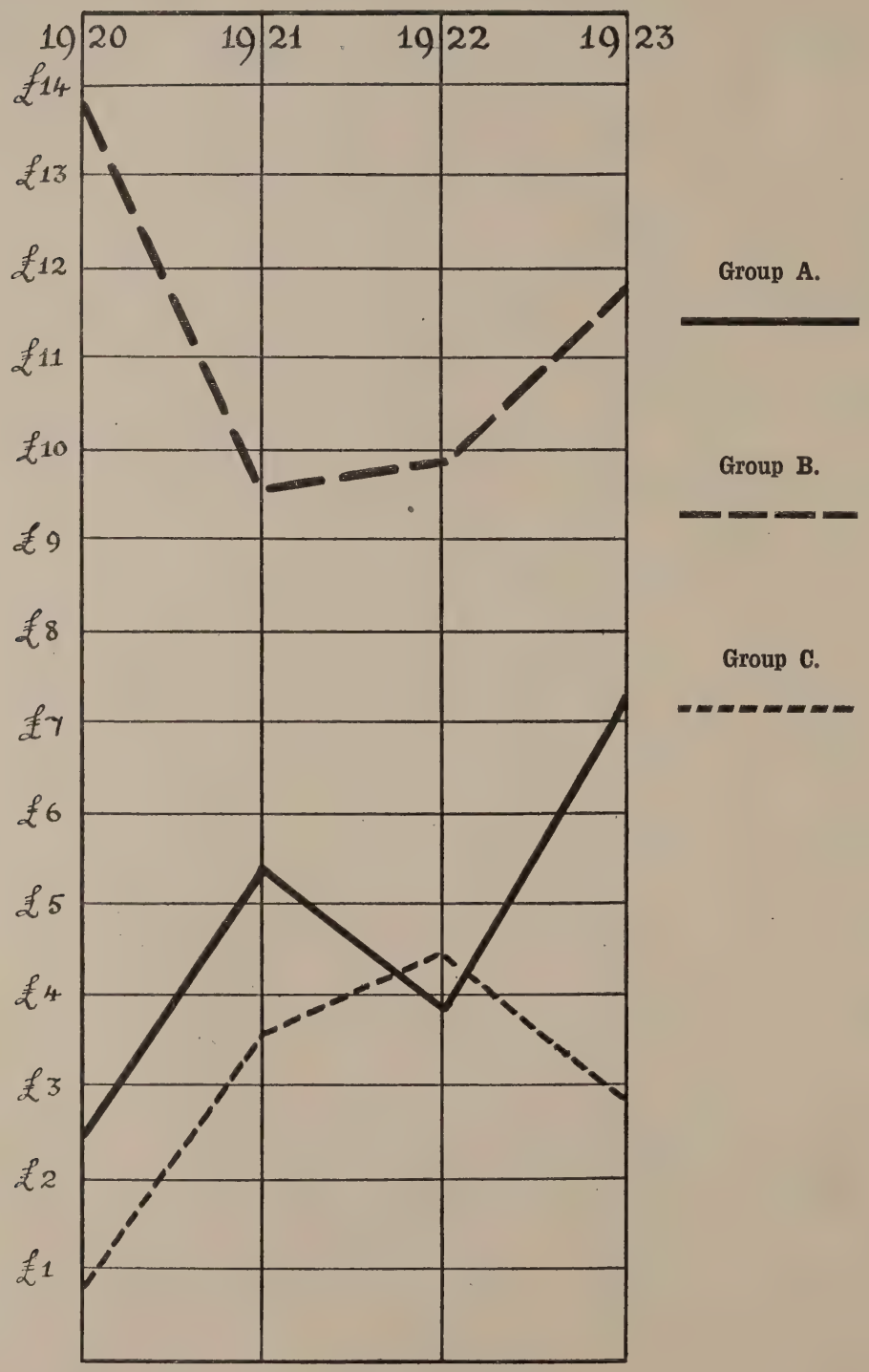
Hospitals.	Year.	No. of Hospitals.	Total Income from Public Services.	Amount per available bed.
Group A	1920	18	£32,435	£6·60
	1921	17	35,553	6·89
	1922	18	28,523	5·37
	1923	**19**	**40,537**	**7·46**
Group B	1920	21	18,813	16·56
	1921	20	11,903	10·42
	1922	20	12,144	10·54
	1923	**20**	**13,894**	**12·09**
Group C	1920	39	1,447	2·62
	1921	38	2,736	4·70
	1922	41	2,880	4·74
	1923	**47**	**2,224**	**3·00**
Total	1920	78	£52,695	£7·98
	1921	75	50,192	7·29
	1922	79	43,547	6·16
	1923	**86**	**56,655**	**7·73**

AMOUNT PER AVAILABLE BED DERIVED FROM PATIENTS' CONTRIBUTIONS.



Illustrating Table 50.

AMOUNT PER AVAILABLE BED DERIVED FROM PUBLIC SERVICES (EXCLUDING WAR OFFICE, ADMIRALTY AND MINISTRY OF PENSIONS).



See page 69.

TABLE 52.

ANALYSIS OF THE SOURCES OF INCOME FROM PUBLIC SERVICES.

Hospitals.	Year.	War Office or Admiralty.	Ministry of Pensions.	Infant Welfare & Maternity Work.	Venereal Diseases.	Tuberculosis Cases.	Education Authorities.	National Health Insurance Act.	Details not given.
Group A ...	1920	£558	£19,331	£1,628	£9,500	£309	£185	£401	£523
	1921	—	7,390	8,772	12,911	652	151	3,581	2,096
	1922	—	7,679	5,166	9,442	512	8	4,665	1,051
	1923	—	**989**	**3,210**	**9,765**	**787**	**14**	**7,757**	**18,015**
Group B ...	1920	25	2,949	370	7,527	835	254	123	6,730
	1921	2	971	515	7,496	2,139	290	171	319
	1922	74	626	522	8,049	2,130	105	178	460
	1923	—	**362**	**2,122**	**7,848**	**2,299**	—	**651**	**612**
Group C ...	1920	63	911	15	—	—	—	173	285
	1921	30	606	556	—	261	53	355	875
	1922	—	156	807	—	604	34	15	1,264
	1923	—	**46**	**720**	—	**5**	**61**	**120**	**1,272**
Total	1920	£646	£23,191	£2,013	£17,027	£1,144	£439	£697	£7,538
	1921	32	8,967	9,843	20,407	3,052	494	4,107	3,290
	1922	74	8,461	6,495	17,491	3,246	147	4,858	2,775
	1923	—	**1,397**	**6,052**	**17,613**	**3,091**	**75**	**8,528**	**19,899**

TABLE 53.

PAYMENTS BY OR ON BEHALF OF PATIENTS.

Hospitals.	Year.	No. of Hospitals.	Total payments by or on behalf of Patients.	Amount per available bed.
Group A	1920	18	£57,590	£11·71
	1921	17	65,768	12·74
	1922	18	56,991	10·72
	1923	**19**	**62,788**	**11·55**
Group B	1920	21	28,989	25·52
	1921	20	30,180	26·42
	1922	20	28,796	24·99
	1923	**20**	**31,311**	**27·25**
Group C	1920	39	8,289	15·01
	1921	38	12,064	20·73
	1922	41	11,528	18·99
	1923	**47**	**12,725**	**17·15**
Total	1920	78	£94,868	£14·36
	1921	75	108,012	15·69
	1922	79	97,315	13·75
	1923	**86**	**106,824**	**14·58**

TABLE 54.

INCOME DERIVED FROM SUBSCRIPTIONS AND DONATIONS.

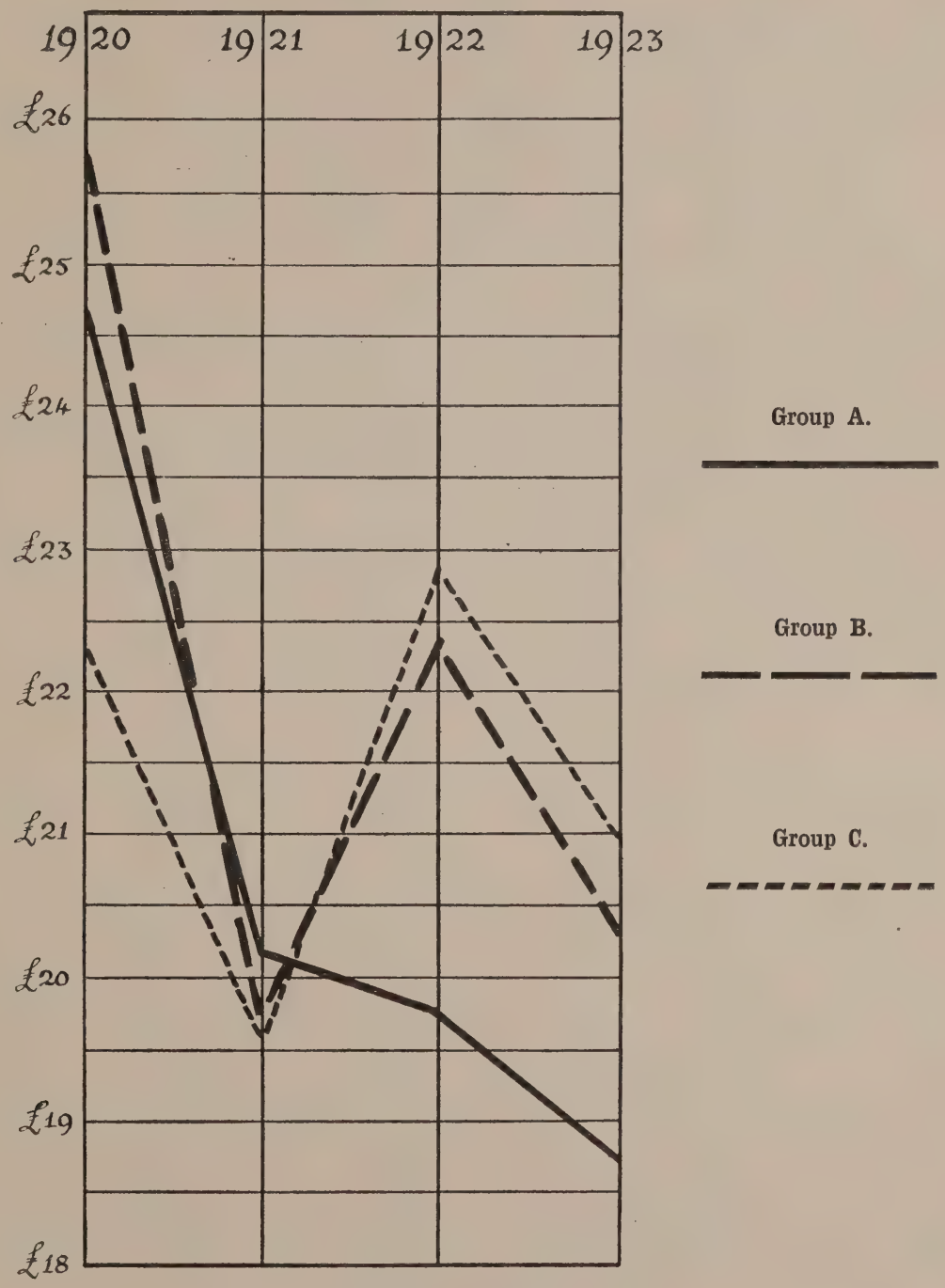
Hospitals.	Year.	No. of Hospitals.	Total Subscriptions.	Amount per available bed.	Total Donations (including Entertainments, etc.).	Amount per available bed.
Group A	1920	18	£121,335	£24·67	£86,528	£17·59
	1921	17	104,187	20·18	102,495	19 85
	1922	18	105,129	19·78	90,941	17·11
	1923	**19**	**101,855**	**18·74**	**82,124**	**15·11**
Group B	1920	21	29,265	25·76	14,058	12·37
	1921	20	22,605	19·79	18,551	16·24
	1922	20	25,816	22·41	15,573	13·52
	1923	**20**	**23,378**	**20·35**	**21,985**	**19·13**
Group C	1920	39	12,341	22·36	6,765	12·26
	1921	38	11,399	19·59	8,858	15·22
	1922	41	13,902	22·90	8,599	14·17
	1923	**47**	**15,561**	**20·97**	**12,070**	**16·27**
Total	1920	78	£162,941	£24·67	£107,351	£16·25
	1921	75	138,191	20·07	129,904	18·86
	1922	79	144,847	20·47	115,113	16·27
	1923	**86**	**140,794**	**19·20**	**116,179**	**15·86**

TABLE 55.

SUMMARY OF ANALYSIS OF ORDINARY INCOME.

Hospitals.	Year.	No. of Hospitals.	Amount per available bed received from :—						
			Interest from Investments.	Workmen's Contributions, etc.	Patients' Contributions.	Income from Public Services.	Subscriptions.	Donations.	Total Amount from the six sources.
Group A ...	1920	18	£20·20	£26·02	£5·11	£6·60	£24·67	£17·59	£100·19
	1921	17	19·83	28·79	5·85	6·89	20·18	19·85	101·39
	1922	18	22·47	26·31	5·36	5·37	19·78	17·11	96·40
	1923	**19**	**24·22**	**25·56**	**4·09**	**7·46**	**18·74**	**15·11**	**95·18**
Group B ...	1920	21	17·97	12·88	8·96	16·56	25·76	12·37	94·50
	1921	20	20·01	13·32	16·00	10·42	19·79	16·24	95·78
	1922	20	23·03	11·28	14·45	10·54	22·41	13·52	95·23
	1923	**20**	**25·24**	**12·74**	**15·16**	**12·09**	**20·35**	**19·13**	**104·71**
Group C ...	1920	39	30·64	16·32	12·39	2·62	22·36	12·26	96·59
	1921	38	28·63	14·24	16·03	4·70	19·59	15·22	98·41
	1922	41	27·68	11·49	14·25	4·74	22·90	14·17	95·23
	1923	**47**	**29·04**	**14·41**	**14·15**	**3·00**	**20·97**	**16·27**	**97·84**
Total ...	1920	78	£20·69	£22·95	£6·38	£7·98	£24·67	£16·25	£98·92
	1921	75	20·60	25·00	8·40	7·29	20·07	18·86	100·22
	1922	79	23·01	22·59	7·60	6·16	20·47	16·27	96·10
	1923	**86**	**24·91**	**22·42**	**6·85**	**7·73**	**19·20**	**15·86**	**96·97**

AMOUNT PER AVAILABLE BED DERIVED FROM ANNUAL SUBSCRIPTIONS.



Illustrating Table 54.

TABLE 56.

CONGREGATIONAL COLLECTIONS, INCLUDING HOSPITAL SUNDAY FUNDS.

Hospitals.	Year.	Total Congregational Collections.	Amount per available bed.
Group A ...	1922	£21,776	£4·10
	1923	**23,424**	**4·31**
Group B	1922	930	0·81
	1923	**1,567**	**1·36**
Group C	1922	1,261	2·08
	1923	**1,326**	**1·80**
Total	1922	£23,967	£3·39
	1923	**26,317**	**3·59**

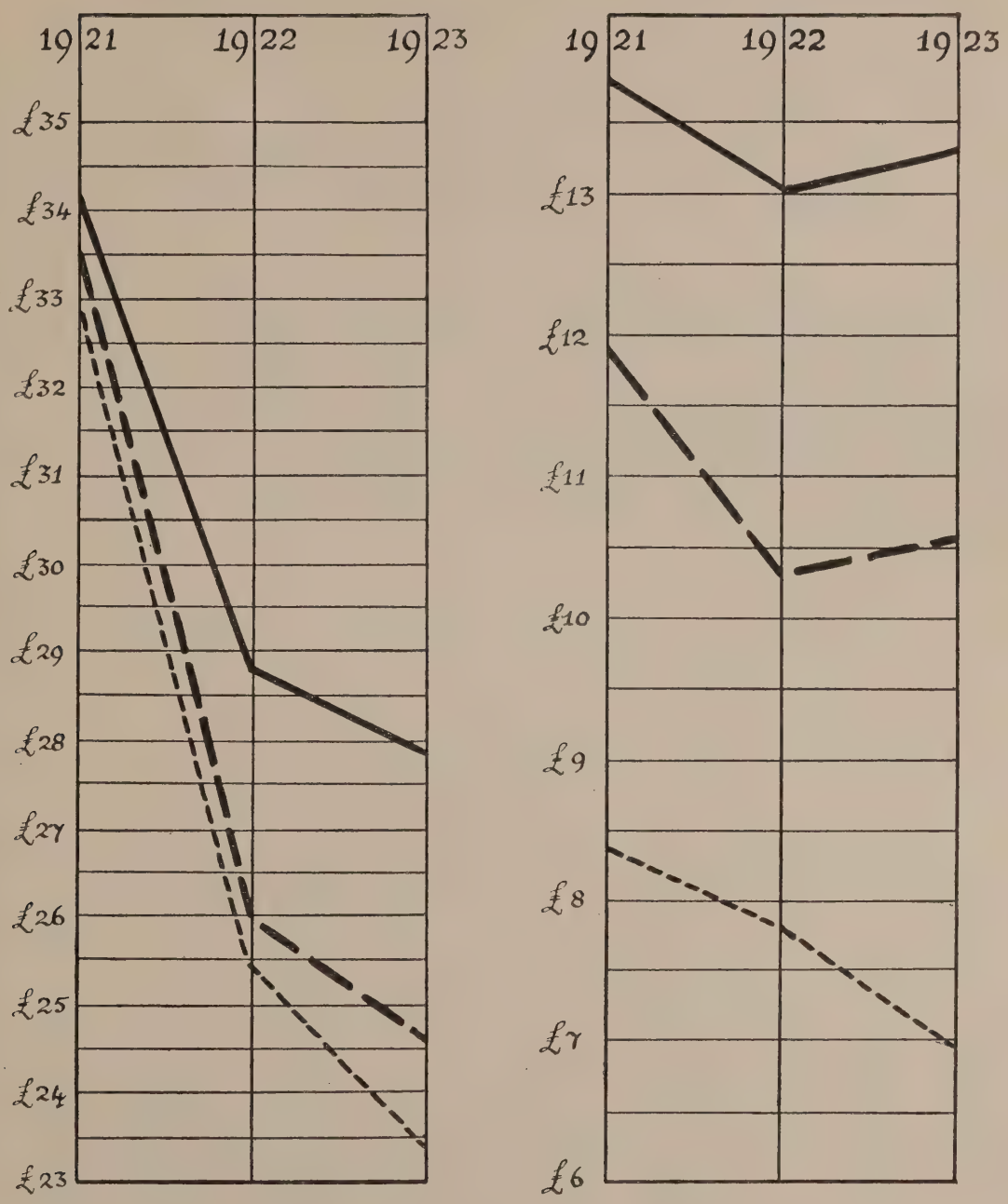
TABLE 57.

SOME OF THE SOURCES OF ORDINARY INCOME OF THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Interest on Investments.	Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes.	Patients' Contributions.	Income from Public Services.
A	1920	£6,994	£3,576	£1,721	£2,975
	1921	7,115	3,589	1,643	2,636
	1922	6,526	3,437	1,543	2,733
	1923	**6,811**	**3,413**	**1,611**	**4,274**
B	1920*	9,802	3,754	1,545	—
	1921*	10,757	5,800	2,218	—
	1922*	9,948	4,670	6,315	—
	1923	**9,602**	**4,693**	**1,347**	—
C	1920	16,839	29,287	3,074	13,818
	1921	19,198	33,044	3,273	7,425
	1922	21,065	34,294	2,602	5,769
	1923	**21,864**	**37,416**	**1,873**	**13,553**
D	1920	11,248	30,934	1,378	2,481
	1921	11,884	30,939	2,398	3,561
	1922	14,690	29,030	2,539	3,061
	1923	**16,939**	**28,953**	2,033	**3,071**
E	1920	9,094	20,583	—	3,984
	1921	10,003	28,587	35	3,608
	1922	10,304	25,691	2,060	3,528
	1923	**12,784**	**21,115**	**1,758**	**5,792**
F	1920	7,154	8,534	654	—
	1921	7,996	12,087	1,463	401
	1922	10,391	12,121	352	926
	1923	**13,181**	**10,247**	**949**	**526**
Total	1920	£61,131	£96,668	£8,372	£23,258
	1921	66,953	114,046	11,030	17,631
	1922	72,924	109,243	15,411	16,017
	1923	**81,181**	**105,837**	**9,571**	**27,216**

* Year ended 15th May.

EXPENDITURE PER AVAILABLE BED.



Group A

Group B

Group C

Illustrating Table 58.

SECTION 10.

ANALYSIS OF THE PRINCIPAL EXPENDITURE OF THE VOLUNTARY

The figures for 1923 in Table 58, which analyses the principal items of Ordinary Expenditure per available bed, testify to the closeness of the watch that is kept upon controllable expenditure in the Hospitals as a whole. It is in these days no easy matter to prevent costs going up. In only one item, "Surgery and Dispensary," was there any increase, and even in this item the increase is extremely small. Several Hospitals refer in their Reports to the cost of Insulin. The Hospitals cannot carry out their proper function unless they have freedom to make use of, and test, new and often expensive remedies, and any restriction in this direction, while it might keep costs down, would not be in the interest of progress.

TABLE 58.

ANALYSIS OF THE PRINCIPAL ITEMS OF

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Provisions.		Surgery and Dispensary.	
				Total.	Per available bed.	Total	Per available bed.
Group A	1921	17	5,163	£171,371	£34·16	£71,232	£13·80
	1922	18	5,316	153,294	28·84	69,451	13·06
	1923	**19**	**5,435**	**151,811**	**27·93**	**72,605**	**13·36**
Group B	1921	15	899	30,145	33·53	10,751	11·96
	1922	19	1,068	27,813	26·04	11,033	10·33
	1923	**19**	**1,065**	**26,265**	**24·66**	**11,244**	**10·56**
Group C	1921	29	479	15,790	32·97	4,029	8·41
	1922	31	493	12,558	25·47	3,848	7·81
	1923	**36**	**610**	**14,274**	**23·40**	**4,232**	**6·94**
Total	1921	61	6,541	£222,306	£33·99	£86,012	£13·15
	1922	68	6,877	193,665	28·16	84,332	12·26
	1923	**74**	**7,110**	**192,350**	**27·05**	**88,081**	**12·39**

ITEMS OF ORDINARY HOSPITALS IN SCOTLAND

In this Table there are in each group (excluding totals) 4 sets of figures or points at which comparisons between the years 1922 and 1923 can be made. If these points are examined it will be found that out of a total of 12 there are 8 where the 1923 figures show a reduction. Of the increases shown in the remaining four only one exceeds the fraction of £1.

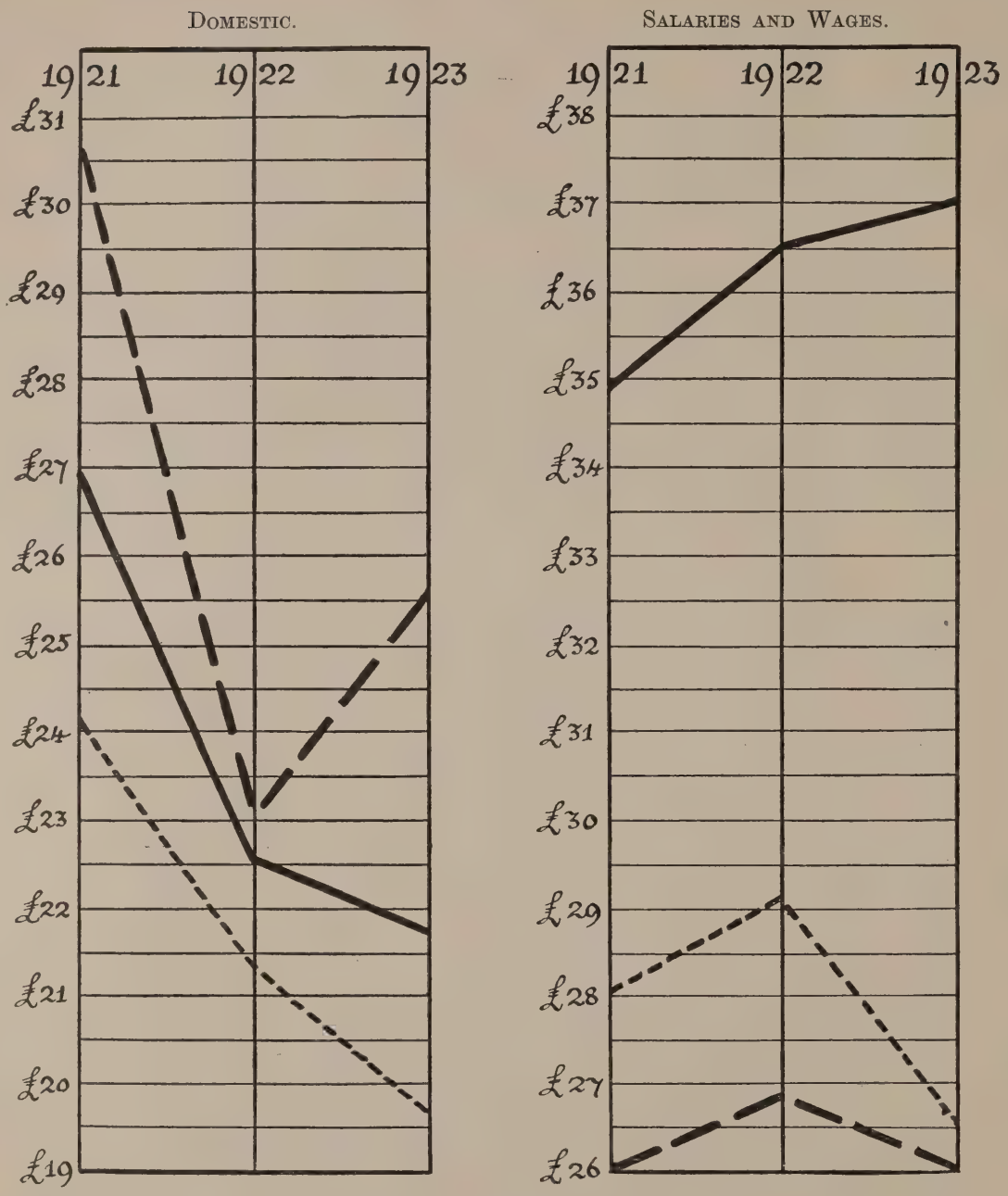
Table 59 analyses similar items in the Hospitals connected with Medical Schools. Here the figures are even more satisfactory, for out of 24 points of comparison no less than 19 show decreases.

Table 60 shows expenditure on Fuel and Light in a certain number of Hospitals, giving details. On the available bed basis the figures for 1923 show a slight fall.

ORDINARY EXPENDITURE BY GROUP AVERAGES.

Domestic.		Salaries and Wages.		Total Expenditure under the four headings.	
Total.	Per available bed.	Total.	Per available bed.	Total.	Per available bed.
£139,518	£27·02	£180,635	£34·99	£567,756	£109·97
120,174	22·61	194,522	36·59	537,441	101·10
118,615	**21·82**	**201,335**	**37·05**	**544,366**	**100·16**
27,605	30·71	23,409	26·04	91,910	102·24
24,703	23·13	28,708	26·88	92,257	86·38
27,344	**25·68**	**27,779**	**26·08**	**92,632**	**86·98**
11,593	24·20	13,441	28·06	44,853	93·64
10,550	21·40	14,388	29·18	41,344	83·86
11,990	**19·66**	**16,234**	**26·61**	**46,730**	**76·61**
£178,716	£27·32	£217,485	£33·25	£704,519	£107·71
155,427	22·60	237,618	34·55	671,042	97·57
157,949	**22·21**	**245,348**	**34·51**	**683,728**	**96·16**

EXPENDITURE PER AVAILABLE BED.



Illustrating Table 58.

TABLE 59.

ANALYSIS OF THE PRINCIPAL ITEMS OF ORDINARY EXPENDITURE IN THE SIX HOSPITALS ASSOCIATED WITH MEDICAL SCHOOLS IN SCOTLAND.

Hospital.	Year.	Average No. of beds occupied daily.	Provisions.		Surgery and Dispensary.		Domestic.		Salaries and Wages.	
			Total.	Per occupied bed.	Total.	Per occupied bed.	Total.	Per occupied bed.	Total.	Per occupied bed.
A ...	1921	249·00	£8,768	£35·2	£3,135	£12·6	£7,566	£30·4	£8,776	£35·2
	1922	269·00	6,949	25·8	3,369	12·5	5,956	22·2	8,894	33·1
	1923	**285·00**	**7,184**	**25·2**	**3,810**	**13·4**	**6,081**	**21·3**	**8,997**	**31·6**
B ...	1921*	326·00	11,703	35·9	6,644	20·4	9,397	28·8	10,915	33·5
	1922*	332·33	9,606	28·9	4,568	13·7	8,959	27.0	10,472	31·5
	1923	**333·36**	**8,125**	**24·4**	**3,618**	**10·9**	**7,550**	**22·6**	**11,991**	**36·0**
C ...	1921	869·00	30,585	35·2	13,891	16·0	27,087	31·2	43,238	49·7
	1922	876·00	24,150	27·6	12,810	14·6	20,189	23·0	41,677	47·6
	1923	**897·00**	**22,761**	**25·4**	**14,209**	**15·8**	**18,904**	**21·1**	**41,390**	**46·1**
D ...	1921	680·20	34,076	50·1	13,179	19·4	26,696	39·2	32,888	48·4
	1922	657·90	28,872	43·9	12,784	19·4	19,471	29·6	33,025	50·2
	1923	**722·90**	**28,678**	**39·7**	**13,413**	**18·6**	**19,687**	**27·2**	**35,509**	**49·1**
E. ...	1921	557·00	27,924	50·1	10,753	19·3	24,577	44·1	24,242	43·5
	1922	555·00	26,014	46·9	9,352	16·9	18,894	34·0	30,252	54·5
	1923	**554·00**	**21,571**	**38·9**	**8,809**	**15·9**	**13,432**	**24·2**	**24,731**	**44·6**
F ...	1921	283·00	13,925	49·2	4,745	16·8	8,292	29·3	12,972	45·8
	1922	286·00	11,181	39·1	4,412	15·4	6,479	22·7	14,107	49·3
	1923	**288·00**	**11,037**	**38·3**	**4,444**	**15·4**	**6,477**	**22·5**	**14,319**	**49·7**
Total ...	1921	2,964·20	£126,981	£42·8	£52,347	£17·7	£103,615	£35·0	£133,031	£44·9
	1922	2,976·23	106,772	35·5	47,295	15·9	79,948	28·1	138,427	48·9
	1923	**3,080·26**	**99,356**	**32·3**	**48,303**	**15·7**	**72,131**	**23·4**	**136,937**	**44·5**

* Year ended 15th May.

TABLE 60.

EXPENDITURE ON FUEL AND LIGHT.

Hospitals.	Year.	No. of Hospitals giving details.	No. of available beds.	Expenditure on Coal, Coke, Gas and Electricity.	Expenditure per available bed.
Group A ...	1921	17	5,163	£97,514	£18·89
	1922	15	3,880	53,542	13·80
	1923	**17**	**4,102**	**54,707**	**13·34**
Group B ...	1921	16	937	14,703	15·69
	1922	18	1,032	12,543	12·15
	1923	**19**	**1,113**	**13,595**	**12·21**
Group C... ...	1921	29	479	6,491	13·55
	1922	30	476	5,513	11·58
	1923	**37**	**621**	**6,886**	**11·09**
Total	1921	62	6,579	£118,708	£18·04
	1922	63	5,388	71,598	13·29
	1923	**73**	**5,836**	**75,188**	**12·88**

THE FUTURE RELATIONS OF THE VOLUNTARY HOSPITALS TO THE MUNICIPAL AUTHORITIES.

An Address given by F. N. KAY MENZIES, M.D., F.R.C.P., Etc.,

At the Annual Meeting of the British Hospitals Association,
London, 19*th June,* 1924.

I presume I have been asked to open the discussion upon this subject because during the past fifteen years my duties, as one of the medical officers of the largest Municipal authority in this country, have brought me into very close contact with the principal Voluntary Hospitals in London.

I confess that, had I consulted only my own peace of mind, I can hardly think of anything which would have induced me to accept the invitation of your Council. If my experience as a medical officer has taught me nothing else, at least it has deeply impressed upon my mind the gravity, as well as the extreme difficulty and delicacy, of the problems which are involved in the subject of our discussion.

Paradoxical as it may seem, however, it is just the gravity, as well as the complexity, of the problem which has appealed to me. I hold, and hold strongly, that because the problem is one of such immense importance to the well-being of the community, it is the bounden duty of everyone, who, by reason of training and practical experience, is in a position to do so, to make his contribution, however humble, so long as its sole intention is to assist towards the attainment of the most satisfactory solution. It is in this spirit that I venture to address you to-day.

I should like, in the first place, to remind you of some of the remarkable developments which have taken place during the last fifteen years in the relations between Voluntary Hospitals and Public Health and Education authorities. In London, for example, the year 1909 brought with it the first step in the establishment on a fairly large scale of what we now call the "School Medical Service." For some years prior to 1909 the London County Council had on its staff a small number of medical officers who were continuously engaged in the study of certain problems concerning Health and Education; but in a town with an elementary school population of 750,000, the number of medical officers so engaged was so small as to be almost negligible, according to modern standards. On the other hand, it was an exceedingly able, zealous and active staff, and there can be no doubt that their work demonstrated, amongst other things, that (1) there was an immense amount of disease of a preventable nature in existence amongst these children; and (2) that the educational facilities, provided by the State and the Municipal authorities at great expense to rate and tax payers, could not be properly taken advantage of, owing to the too frequent prevalence of certain diseased conditions, such as, *e.g.*, Defective Eyesight, Defective Hearing, Defective Teeth, Ringworm, Ophthalmia, Trachoma, Tuberculosis, Infantile Paralysis, Rickets, Verminous and Infectious Diseases and a mass of minor ailments, such as Impetigo, etc., most of which were either preventable or easily remediable.

The Education Administrative Provisions Act, 1909, resulted in the gradual introduction of a School Medical Service into the Public Elementary Schools throughout England and Wales. In London, perhaps more so than in most other parts of the country, the growth of the School Medical Service from 1909 onwards was very rapid. In a short time the number of school children examined ran up to between 250,000 and 300,000 per school year. Naturally medical examination was bound to be followed by a demand for Treatment, and it soon became obvious that the flooding of the Out-Patient Departments of Voluntary Hospitals with children found by the Council's medical staff to be suffering from various ailments was giving rise to nothing less than a public scandal.

I do not wish to suggest for one moment that either the Voluntary Hospitals or the General Practitioners had any responsibility for provision of the treatment found to be required in these cases, but I do say that the Public Health or the Education Authority when its attention was directed

thereto was bound to see, unless it chose deliberately to ignore its responsibility, that suitable provision was made for the adequate treatment of these ailments, more especially when it could be shown that many of them were of a preventable nature.

It is unnecessary now to go in any detail into the history of what followed. It will be sufficient for our purposes to say, that ultimately arrangements were made whereby a certain proportion of these children were treated at School Treatment Centres, established in various parts of London and staffed in the main by General Practitioners, and that the remainder were treated at various Voluntary Hospitals by agreement between the Hospitals and the London County Council. So far as I am aware, this was the first public medical service undertaken on any considerable scale by the Local Authority for London. It may interest you to know that in 1923 under these arrangements the

(1) (*a*) Number of children treated in Voluntary Hospitals was 25,984
(*b*) Number of children treated in School Treatment Centres was 194,864,

while the cost of such provision was

(2) (*a*) Hospitals, £9,535.
(*b*) Treatment Centres, £69,757.

I will not attempt to describe in detail the various other medical services which since 1909 have been undertaken by Local Authorities, but I mention, merely for your information, that in London, for example, the main services are

(1) Tuberculosis : Beds, 2,400. Approximate cost, £334,000.
Dispensaries : 33. Approximate cost, £75,000.

(2) Venereal Diseases. Number of hospitals at which clinics have been established, 28. Approximate annual cost, £110,000.

(3) Maternity and Child Welfare Centres, 220. Approximate cost, say, £150,000.

(4) Midwives Act. Fees paid to Medical Practitioners in 1923, £4,300.

I would also remind you that all these services are altogether apart from the great Fever Hospital and Mental Hospital services, as well as the Poor Law medical service to which I shall refer in more detail later on. It is difficult to get accurate figures and, therefore, I hesitate very much to give any, but I believe it to be approximately correct that at least four-fifths of the treatment available for the sick in the metropolitan area is provided for out of rates and taxes.

I have now sketched in brief outline, the extent to which provision is at present made for the treatment of disease in London. I do not think there can be any doubt that these services are certain to expand, and are likely to do so in the near future in certain directions which, hitherto, have either not come within the scope, or only slightly so, of Local Authorities, *e.g.*,

(*a*) Municipal Maternity Hospitals.
(*b*) Certain diseases of childhood, such as Chorea, Rheumatism, Infantile Paralysis, etc.
(*c*) Advanced cases of Tuberculosis, etc., etc.

THE POOR LAW INFIRMARIES.

Future developments in the Poor Law medical service may prove to be a big factor in determining the ultimate relationships of the Voluntary Hospitals and the Municipal authorities. We all know the recommendations of the Maclean Committee with regard to Poor Law Infirmaries which represent the great bulk of the institutional provision for the sick in this country. In the past they have gained a bad reputation in the minds and memories of the poorest section of the community, but it should not be overlooked (and I desire to lay great emphasis upon this point), that whatever their past history may have been, there is absolutely no doubt that in recent years they have taken giant strides towards making themselves thoroughly efficient hospitals, especially in London and some of the large provincial towns. Practically speaking, every Poor Law Infirmary in London to-day has upon its staff a certain number of specialists in various branches of medicine and surgery, and, moreover, they are all paid for their services. Similarly, their technical equipment is as a rule very good.

Their nursing staff is better selected, better paid, better fed, better housed and works shorter hours than they used to, and it is noteworthy that some of these Poor Law Infirmaries are actually setting aside private wards and taking in private patients at fees amounting to as much as three and four guineas per week. There has, therefore, evidently been in some areas a determined effort to make them really efficient hospital units, and with the public purse behind them and a good deal of real enthusiasm for the welfare of their patients, on the part of both the Boards of Management and the medical and nursing staffs, there is no doubt at all that they are rapidly approaching the high standard of efficiency which hitherto has been regarded as the proud preserve of the Voluntary Hospitals.

If this forward movement continues, and by legislative action the "pauper taint" is removed, what do you suppose is going to be the future of these Poor Law Infirmaries? Are they to become merely competitors with the Voluntary Hospitals, or are they to work in co-operation with them?

Before answering these questions, let me ask you to bear one or two points in mind. First, remember that probably the future development of the Poor Law Infirmary is in the direction of a Municipal Hospital, and, secondly, that inasmuch as the Local Authority is already charged with the responsibility for the treatment of Infectious Diseases, Tuberculosis, Venereal Disease, Maternity and Child Welfare, School Medical Service, etc., as well as the organisation for the prevention of disease by means of Improved Housing, Pure Food, Pure Water Supply, Proper Disposal of Sewage, and all other matters which concern the health of the community, it is almost as certain as anything can be in this world, that if it can be shown that the provision of institutional accommodation for the treatment of the sick is inadequate or unsatisfactory in any area, the Local Authority will ultimately be compelled, whether they like it or not, by the mere force of public opinion, to put it right, wherever it is proved to be required.

In the present financial circumstances of the Voluntary Hospitals it is difficult to see, if any large capital expenditure be required (*vide* Cave Committee Report, page 6, paragraph 9), how they can undertake such a responsibility unless, of course, some satisfactory arrangement can be made by their Boards of Management with either the State, or the Municipality, or both.

THE PRESENT POSITION.

Having reviewed the great growth which has taken place in recent years in the responsibilities for the prevention and treatment of disease by the Public Authorities, and having agreed that this development is much more likely to expand than to diminish, we must now ask ourselves what is the present position?

How far are the real needs of the public met by the various organisations, public and voluntary, which in varying degrees throughout the country purport to provide for their needs? How far, in fact, is the problem one of an actual shortage of something which is really needed for the welfare of the community, and how far is it a problem of reorganising and grading our existing available accommodation and personnel. Is it in fact a case of bad organisation, with lack of co-ordination and overlapping and wastage in a hundred different ways, or is it a real shortage of accommodation, equipment and finance? I don't know, and I am perfectly certain no one else knows, with any approach to accuracy.

There has been in recent years a vast amount of talking and writing upon this question, and the more I hear and read of this subject, the more convinced I have become that a great deal of it is ill-informed, badly advised, and not infrequently tainted by political prejudice pure and simple.

The unavoidable post-war financial difficulties of the Voluntary Hospitals—the insistent and quite reasonable demand for the removal of the pauper taint from those individuals who frequently, through no fault of their own, are compelled to resort to the Poor Law Infirmaries for treatment, the immense growth in the Health activities of the Local Authorities, as well as the introduction of the National Health Insurance Acts, have all served to bring about a very complicated position.

In short, it comes to this, that every right-thinking man and woman in this country is beginning to realise that the present position with regard to the prevention and treatment of disease, whether

by voluntary or public authorities, requires review. The time has, in fact, come, to make a careful, comprehensive and detailed survey and study of the situation.*

Such a survey would show the exact provision available from every source, Voluntary, Poor Law, or Public Health. Its comprehensive character would make it possible to visualise the needs of any area, whether rural or urban, or a mixture of both. It would provide an unassailable basis upon which to build an adequate and co-ordinated scheme for the prevention and treatment of disease throughout the whole country.

I cannot see any reason why such a scheme, when drafted, should not provide (1) for the preservation of the best features of the present Voluntary Hospital system; (2) for adequate accommodation, equipment and finance of the hospitals generally; (3) for the geographical distribution of hospitals so as to avoid unevenness and overlapping; (4) for a closer relationship between Voluntary Hospitals themselves; between Voluntary Hospitals and the various classes of hospitals provided by local authorities; and between general practitioners and all the various institutions which treat the sick.

In fact, it seems to me that it is only by means of such a comprehensive survey that it will be possible to give adequate consideration to the various problems concerning the sick, which at present are agitating the minds of those who manage Hospitals, whether voluntary or public; those who represent the medical profession, and last, but by no means least, the general mass of the community, who, after all is said and done, are the people most concerned.

Now the particular point which I wish to drive home this morning and to discuss is this. The Labour Party say they have made such an enquiry and as a result they have formulated a policy. Not only that, but they have taken the trouble to publish it for all the world to read. Similarly, the British Medical Association have given close attention to the same subject, and they have published the results of their deliberations and have also formulated a policy. There are other reports and other policies, some of considerable importance, to which I need not refer. If you read the views of the Labour Party and the British Medical Association and others, you will see that in certain vital matters they differ considerably, for example, in such important questions as the degree of inadequacy of institutional accommodation; on the methods by which Voluntary Hospitals should be subsidised, etc., etc. Now it seems to me that in discussing a question of this kind, it is absolutely essential that the data from which conclusions are drawn should be absolutely correct, and therefore beyond all possible criticism.

What is the British Hospitals Association going to do, in view of these conflicting data and policies? Which of them are you going to accept? Or are you, as representing the Voluntary Hospitals, prepared to follow the example of those two powerful bodies, the British Medical Association and the Labour Party, and set in motion machinery to enable you to play the part to which you are entitled in this vital question? You have done great work in the past, but circumstances have arisen which call for even greater efforts now and in the near future. It lies with you to answer

* Such a survey should include the following, among other items :—

1. Each county area will have to be carefully investigated in order to ascertain not only the exact amount of institutional accommodation for the sick (Voluntary, Poor Law and Public Health), but also all other facilities for diagnosis and treatment such as Dispensaries, Maternity and Child Welfare Centres, Clinics, etc.
2. Having ascertained this information, then it will be necessary to classify it into the various categories—Surgical, Medical, Special Departments, Mental, Fever, Chronic Diseases, etc.
3. The next step would be to ascertain from Medical Officers of Health, Medical Practitioners, Clergy and Ministry, and Social Welfare workers, as well, of course, as the Hospitals themselves, in what respects their experience proves there is a real deficiency.
4. Then, with a full and complete knowledge of the facilities available and the deficiencies found by experience, it would be wise to consider how far known needs could be met by re-arrangement of existing facilities—how far additional Auxiliary Hospitals, Recovery Homes, and Convalescent Homes could meet the need by relieving the larger and more expensive Hospitals of cases now dealt with—how far Public Health Authorities could relieve Voluntary Hospitals of cases of Tuberculosis, etc.
5. Lastly, how far, after such re-arrangement, a real need existed for additional Hospital accommodation, whether Voluntary, Poor Law, or Public Health. It would not necessarily mean any additional Voluntary Hospital accommodation in every area.

certain criticisms which have been made, such as, for example, that the Voluntary Hospitals lack co-ordination, etc., etc. Moreover, you must bear in mind that one of these days the Minister of Health may, in view of these very same conflicting data and policies, decide to appoint a Royal Commission to investigate the whole question. If he does, can you say that you are prepared to meet your critics, armed with unassailable data and a clear and definite policy for submission to such a tribunal?

I would also beg you to keep well in your minds the fact, that there is a very real danger that at some time in the near future the whole question of the treatment of the sick will be thrown into the political cockpit, and that we may have a recrudescence of that lamentable exhibition of mutual recrimination which characterised the era of the introduction of National Health Insurance in 1911.

In this short paper I have deliberately refrained from examining the policy of the Labour Party, as set forth in their Pamphlet entitled "The Labour Movement and the Hospital Crisis," or the policy of the British Medical Association, as set forth by Mr. Bishop Harman in the supplement to the *British Medical Journal* of May 3rd, 1924, or, indeed, many other important contributions made upon this subject by such authorities as the Cave Committee, or Viscount Knutsford in his address at the Caxton Hall on April 28th last, because I do not think I shall serve any useful purpose thereby.

The time for attack;ng and defending a policy from an individual or even a corporate point of view has gone. WE are all heartily tired of it, and what we all most earnestly desire is a satisfactory solution of our difficulties.

Before concluding, I should like to emphasise my firm conviction that in this, as in many other questions of national importance, the view so frequently expressed that any survey, undertaken on the lines which I have indicated, will reveal the necessity for a vast capital expenditure, will probably prove to be erroneous. Moreover, I believe that such a survey will considerably enhance the great reputation already possessed by our Voluntary Hospitals and enable them to play an even greater part in the future in the work which for centuries past they have carried out for the welfare of the community.

If we reflect upon the history of the prevention and treatment of disease in this country, we shall find that in its early stages the Voluntary Hospitals and the Municipal Authorities occupied limited and separate areas, leaving untouched much work of great importance to the community, from the point of view of the national health. As medicine and surgery advanced and the value of institutional treatment came to be more and more fully recognised, we find the line of demarcation growing less and less distinct and the two bodies drawing gradually closer and closer together and in some cases actively co-operating to the great advantage of the health of the nation.

It is impossible to suppose that the movement thus begun will stop short of anything less than a full and complete health service, available for all who require it. Therefore, I cannot too strongly impress upon you my view, that the steps which you now take, and the policy which you adopt in the near future, will largely determine the future relationship between yourselves and the Municipal Authorities. Moreover, in my judgment, the efficiency of the health service will, in large part, depend upon the establishment of intimate co-operation and harmonious relationship between the Voluntary Hospitals and the Municipal Authorities.

HOSPITAL ACCOUNTS.

A Statement of the Principles upon which Hospital Accounts should be based.

BY

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INTRODUCTION.

Not more than 30 years ago the typical hospital organisation was one with a relatively small amount of invested capital and annual income and expenditure. Its problems of management, judged by present standards, were not especially complex, and the Management Committee found little difficulty in keeping itself familiar with most of the affairs of the hospital. It was rarely that the scope of activities of any single hospital was so wide as to affect vitally any large community interest. From this it follows that the accounts required to record its financial transactions were of a fairly simple type, and were of interest usually to only a few persons. The conventional *annual* statement of account setting forth the cash received and disbursed was found to be entirely adequate to the needs of the typical hospital enterprise of the period. The faithful recording of cash transactions and the preparation of the annual statement were, indeed, thought to be the highest point of development in hospital accounting.

The increasing size and complexity of modern hospital business has, however, caused a new orientation in hospital administration. Hospital work does not now consist solely of the treatment of the sick; teaching, research, and healing are carried on side by side, and no large general hospital is considered worthy of the name unless it be equipped with special departments and apparatus for radiography, massage, electrical treatment and so forth, while, in addition, many hospitals now run their own laundries, and a still greater number provide convalescent homes and homes or special wards for the reception of paying patients.

MODERN SYSTEM OF ACCOUNTING ESSENTIAL.

As the activities of hospitals grow, so does expenditure, and so much more essential is it that those responsible for the administration of hospitals should know continuously the cost of each and every one of their activities so that they may be efficiently and economically administered. The Governing Body of a hospital are in effect trustees for the public of the money they have contributed, and as such they have three very important duties to perform :—

1. To account strictly for all moneys entrusted to their charge.
2. To secure that in spending such moneys the greatest economy consistent with efficiency is exercised.
3. To ensure that the services rendered are adequate and satisfactory in quality.

The aim of a hospital, then, may be said to be a threefold service to the community, viz. :—

1. A quantitative service—to treat as many patients as possible.
2. A qualitative service—to cure the largest possible percentage of those treated.
3. An economy service—to render maximum quantitative and qualitative service at minimum cost.

The performance of number three implies the possession and recognition of a careful analysis of facts which relate to both the external and internal business transactions of the hospital, *and the acting in the light of their interpretation.* These facts can only be obtained from a system of accounts which conforms to the organisation of the hospital. *Hospitals are organised according to wards, departments, activities and the like, and obviously, if accounts and the analyses of accounts are to be capable of intelligent use by the administration, these specific units of organisation must form the entities upon which they—the accounts—are based.* Unless the particular nature of the services upon which the money is spent is taken as the basis upon which units of cost are erected, there can be no unassailable deductions drawn, either for internal administrative control, or external comparative purposes. In other words, expenditure must be classified according to the use to which it is put, *i.e.*, the method employed must be an objective one. If we review the present system of Hospital accounts, we find that expenditure is divided into a number of main heads, which are again divided into sub-headings showing details. Each main head represents a specific group of expenditure, and within the limits of each of these and the sub-heads the details of Hospital expenditure must be set out with minute accuracy. Analysis of expenditure must conform exactly to these headings, and this strict adherence to form is a sacred rule of Hospital accounting. The natural divisions of expenditure, so essential to control and efficient administration, are not exhibited. Expenditure is classified to distinguish only between certain types, rather than to bring these different types of expenditure in relation to the functions or services with which they are connected. It will be readily understood that knowledge of totals of groups of unrelated expenditure is of little use to a keen administration. The defects of the present system are clearly shown in the following examples:—The elements of the cost of heating are hopelessly entangled in the expenditure accounts. The wages of engineers and stokers appear under "Salaries and Wages"; coal under "Domestic"; water under "Domestic"; renewals and repairs of plant under "Establishment"; etc., etc. Stated thus, the cost of heating is not shown. It is incapable of being considered in relation to any activities whereby its efficiency and its efficient use may be measured. Thus, an important item of cost in all Hospitals is lost to sight by reason of its constituent elements being merged with other elements which happen to have a similar designation. The same remark applies to Hospital laundries, although here the principles of departmentalisation are recognised to the extent that a separate statement of laundry cost is shown. Another serious defect of the system—and this applies more particularly to the question of comparisons between Hospitals—is that practically the whole of the ordinary expenditure is reduced to the unit of the "occupied bed." Hospital officers are under no misapprehension as to the value of this single unit for the purpose of such comparisons. When, for instance, regard is had to the wide range of differences existing among Hospitals as to the nature and extent of the specialised treatment available, this unit for comparative purposes is absurd. Some Hospitals possess elaborate and most up-to-date apparatus for radiology and electrical treatment, while in others the equipment may be very limited and the work negligible. Some Hospitals have laboratories for bacteriology and chemical pathology, specially equipped and employing salaried officers, while in others there is practically no such work. Again, massage is now recognised as a valuable form of treatment. In some Hospitals it is practically non-existent; in others there is a special equipment both in staff and material. Then again, there are marked differences in the number and nature of departments and the nature and extent of research work, etc., carried on. *The inadequacy of the present system has long been recognised, and this recognition has resulted in the gradual addition of numerous subsidiary methods of control.* These include detailed statistics of stores issued for consumption, wages' analysis, exhaustive dissection of expenditure on subjects, etc., and recently a system of quantity statistics has been introduced by the King's Fund. Detailed statistics, however, which are not brought under accounting control, are far from satisfactory; but that their preparation is considered necessary is useful as showing an attitude of mind, which if carried to its logical conclusion, will result in the introduction of a new and comprehensive system of accounting for Hospitals based on the principles set out in this article. *Control of expenditure cannot be obtained by controlling expenditure on subjects.* If it is desired to establish control of expenditure, it can best be effected by the objective method. The difference between the two methods is shown in the following illustration:—Linen purchased in bulk and stored for future issue may subsequently be used in wards, departments and staff quarters. The Assistant whose duty it is to analyse the accounts cannot, under the present methods of Hospital accounting, tell for what services

the linen will be used, but he can see from the account the nature of the goods purchased—he has no difficulty in classifying it as "Domestic" (renewals and repairs of bedding and linen), and he records the amount under this heading. This is known as the subjective method of analysis, and it is the basis of the present system. Under the objective method, the expenditure is classified according to the use to which it is put, *i.e.*, by activities or services. As will be seen later, this method retains all the advantages claimed for the subjective method and in addition it provides a most valuable link in the chain of internal financial control.

THE ORGANISATION.

The objective method of accounting follows the organisation of the hospital, and before discussing the principles of the method it will be worth while to consider briefly of what the organisation of a hospital consists. Obviously it must provide for at least three functions :—

1. The policy making function.
2. The executive function (the management).
3. The staff function (the organisation).

The policy making function resides in a Court of Governors, and it is the function concerned with the determination of Hospital policy, the settlement of the compass of the organisation, and the ultimate control of the work of management. As the supreme authority, it has a dual function ; firstly, the business of determining policy, or what may be called the "determinate" element of administration ; secondly, the business of controlling the execution of policy, or what may be called the "co-ordinating" element of administration.

Management, or the executive function, is concerned with the execution of the policy and the use of the organisation for the attainment of the particular objectives set before it.

Organisation is a state of affairs in which duties are allocated to certain individuals in such a way that their performance results in the accomplishment of the specific purposes desired. It is composed chiefly of two parts, the *functions* to be performed, and the *faculties* by which these functions are performed, the operation of the latter upon the former determining the duties. Organisation is, therefore, the problem of so combining the work which individuals or groups of individuals have to perform with the faculties necessary for its execution, that the duties performed provide efficient, systematised and co-ordinated service.

Broadly, then, we may say that the Governors determine the policy and ultimately control management in carrying out that policy. Management carries out the policy determined by the Governors and organisation provides the channels through which management is to operate.

The organisation should be classified so that it will fall into certain well-defined major departments, and the heads of these major departments will organise the activities of the respective departments into functional groups with a responsible officer in charge of each.

PRINCIPLES OF PROPOSED ACCOUNTING SYSTEM FOR HOSPITALS.

Given an organisation that can be held accountable, the next consideration is the introduction of a system of accounts which will hold the organisation accountable. Special emphasis is placed on this, as under the present system the accounts have no relation to the organisation, and are generally regarded as an end in themselves.

Hospital accounts, if they are to serve the purpose for which they are intended, should conform to the following principles :—

1. *The basis or starting point of the system must be a chart showing all the units of the organisation.*
2. *The introduction of a Hospital budget based on this chart.*
3. *The inception of a separate account for each unit of the organisation. Within each account the analysis of expenditure to be grouped under appropriate headings distinguishing between that which is controllable and that which is uncontrollable.*

4. *The reduction of the total expenditure in each account to a unit of cost, each unit being determined solely by the nature of the service rendered.*

5. *The system must be based on pure expenditure lines representing the true cost for the period under review. This involves the keeping of Stores Accounts.*

Each of these principles could well form the subject of a separate article, and it is only possible to touch upon them briefly here.

THE HOSPITAL BUDGET.

Efficient administration of hospital finance requires a close co-ordination of income and expenditure, and like the co-ordination of commercial income and expenditure, this requires careful planning. When this planning is done in a systematic manner it results in budget making. A budget is a statement of the estimated income and expenditure of the hospital for a certain future period of time, set out in such form and supported by such collateral data as will show its financial needs and income possibilities. The preparation of the budget compels a desirable and advanced concentration by all departments of the Hospital on their future needs, and it provides a basis for intelligent consideration by the finance committee of monthly comparative statements of expenditure. *It provides for the control over expenditure before the expenditure is incurred.*

To shew the need for a Hospital budget is an easy task, but to secure the introduction of an effective budget is more difficult. Such a budget pre-supposes three things :—

1. A definite and accountable organisation for the management of Hospital affairs.
2. A system of accounts so designed and maintained that they will serve as a basis for holding the organisation accountable.
3. A budget prepared in such form that it will represent a system of future accounts stated in terms of organisation responsibility.

THE ORGANISATION UNIT ACCOUNTS.

It follows naturally that an accounting system is a prequisite to the preparation and enforcement of a Hospital budget. A satisfactory budget cannot be based on the imagination of executive officers. It must be based upon experience as reflected in the accounting records, modified by future needs and income possibilities. After the budget is prepared it must be enforced, and a system of accounts is necessary for such enforcement. It is idle to allot a certain amount of funds to a department if no record is kept of its expenditure so that it will be restricted to the allotment. The opening of a separate account for each unit allows the system to harmonise with the form of the budget, and we see here the inseparable relation between organisation, accounting and the budget. It needs little imagination to realise that a system so designed can be made a very effective instrument for securing and maintaining administrative control. It offers not only a continuous record of financial performance, but a means for studying the performance in an analytical way, and thus provides information allowing for the relative degree of efficiency of any activity to be properly determined. The responsible officers will be informed continuously in terms of £. s. d. the cost to the Hospital of what they *are* doing. Apart from the silent control invariably introduced by the figures themselves, they also help to develop the money sense in administrative officers. The responsibility for the quality and economical purchase of supplies will be with the supplying departments and the responsibility for the cost of consumption of supplies, with those who demand them.

Hospital officers have unconsciously practised the principles of analytical accounting, but not quite in the way suggested here. Comparison in its development usually proceeds from the general to the particular. The annual Income and Expenditure Account, for instance, is compared with those of preceding years, and while such comparison is at best a *post mortem* examination it is of some interest, but not of much use in assisting the administration, nor for future guidance. The measure of its utility will be determined by the foresight exercised in designing the subsidiary records from which the account is prepared. Any serious fluctuations revealed by such comparison, especially

if they are increases in expenditure, usually give rise to a hurried search for the causes. Such comparison, with all its limitations, is useful again in denoting an attitude of mind, and it is yet another instance of a first stage in conscious analysis which, if carried to its logical conclusion, will create a demand for a system of accounts which will allow of the *expenditure on each activity* being obtained continuously throughout the year.

THE UNITS OF COST.

The units for which the costs are calculated must be determined solely by the nature of the services rendered. This principle is so obvious that there is no necessity for it to be elaborated. Such units may be "per bed" for wards, "per operation" for theatres, "per examination" for X-rays, "per mile" for ambulance, and so on. Units of consumption would also be prepared, such as plates per examination for X-rays, anæsthetic per operation, petrol per mile, etc.

TRUE INCOME AND EXPENDITURE.

The fifth principle involves another fundamental change in the present system. With the increase in knowledge of accounting it is unnecessary to explain at length the inadequacy of the cash-receipts-and-payments-system as a basis for exercising administrative control. Knowledge of the *true* position is required, and this can only be provided by the income and expenditure system, which includes such factors as consumption of stores, outstanding expenditure, assets and liabilities, depreciation, interest, etc.

The maintenance of accounts of true expenditure (as distinct from cash payments) is the method adopted by all commercial undertakings, not because they *are* commercial undertakings but because they recognise that it is the correct and most efficient method.

ADVANTAGES OF PROPOSED SYSTEM.

The putting into practice of the principles enunciated above would result in a more highly developed form of accounting for Hospitals, and one less influenced by mere convention. Each unit of the organisation would shew its own total cost, and its unit cost. These units of cost are again capable of being divided to shew the cost of each constituent element, and by means of these it is possible to ascertain the differences which arise from varying conditions.

Briefly, the accounts would provide :—

1. A record of *material* statistics of the greatest use to a keen administration.
2. A standard on almost every unit of Hospital activities.
3. A guide for the making of future budgets and the formation of sound policies.
4. A stimulus to economy.
5. An indication for the detection of waste and extravagance.
6. A means of comparing the cost of work done by direct labour as compared with outside contract. This applies both to Works Departments and to the manufacture of drugs, surgical sundries, etc.

The accounts would answer every material question that the present accounts answer. *There is nothing expressed in the present accounts which in the form suggested is not expressed in truer relationship to the actual facts,* and in addition, a wealth of scientifically classified statistical data would be available. The importance of statistics cannot be overlooked. The new school of thought in Hospital finance recognises in them a method of assisting the administration which has very definite possibilities. On the other hand, there are others who are very apt to condemn statistics altogether, or to expect too much from them. This attitude arises largely from failure to appreciate the distinction between the unorganised and relatively aimless statistics of the present day and those organised and purposeful *related* facts and figures produced by a system of accounts on the organisation unit basis. These statistics open up an entirely new field of control. The administration would see them not as historical documents, but as barometers ; not as mere results, but as present tendencies ; not as reflections, but as something pointing the way to the solution of current problems.

Other considerations make it equally desirable that Hospital accounts should be based upon more up-to-date principles. The Ministry of Health now requires the submission of detailed statements of expenditure on certain services in connection with claims for grants. These services include V.D., Maternity and Child Welfare, Tuberculosis, etc., the maintenance of which are of national importance. With the growth in Hospital activities this practice will grow. Hospitals to-day are working more and more in conjunction with public authorities, and it is essential that the financial clauses of agreements in respect of patients for whom such bodies are responsible should be on the soundest basis possible, so that equitable treatment may be obtained from such authorities, who should be just but who have no right to be generous.

Again, one looks in vain in the published reports of Hospitals for any account of the cost incurred in maintaining such valuable subsidiary departments as X-rays, electrical treatment, massage, research, etc. These reports appear year after year in the same form with only the figures altered, whereas by inserting figures relating to the activities conducted, emphasising those to which it is desired to direct special attention, and informing the public of the extent of the research work carried on, and the cost, they could be transformed into very effective collectors. A Hospital which shows that it knows exactly how it stands throughout the year and in what directions it is spending its resources, can go with much greater confidence and sureness of success to the public and interested parties than it can if the only financial data it has to support its claim is based on an annual account which gives all in costs, treatment, and research intermingled.

The above arguments in favour of the introduction of an improved system of accounts for Hospitals on modern principles all have more or less weight varying in different cases. All of them together, however, are less important than certain indefinable but very real advantages resulting from a system which concerns itself with those matters that are of real interest to a keen administration, and which leaves non-essentials alone. The difference between an administration which is well informed and one which is uninformed or half informed can no more be covered by specific points than the benefits of a good education can be covered by giving isolated examples of its practical use. The steady and consistent flow of reliable data through the minds of the administration cannot fail to generate an understanding; an enlightened comprehension which will work itself out in sound policies and efficient administrative procedure.

ACCOUNTABILITY OF OFFICERS.

Although Hospitals cannot and should not present the results of their activities in terms of profit and loss, they can and should shew as a minimum, accountability in reference to the following items :—

1. Honesty of expenditure.
2. Expenditure in conformity with any regulations which exist.
3. Efficiency in expenditure, ascertained by activity costs in terms of services rendered.
4. The care and custody of assets and their proper use.
5. Liabilities incurred.
6. Funds available for each activity.
7. Efficiency of administrative procedure.

This list is not conclusive, and the items are mentioned merely as a challenge of what the possibilities of Hospital accounting are in the placing of responsibility and the judging of efficiency.

HOSPITAL PROPERTY.

It will be noticed that No. 4 proposes to hold the officers responsible for the care, custody and proper use of Hospital property. This is a phase of Hospital administration which has not received the attention it deserves. Accounting control is considered absolutely necessary for cash transactions. Cash in hand or at the bank is looked upon as something sacred, and members of committees and executive officers would not think of dealing with it without some form of ritual. Let (say) £100 of this cash be turned into an asset of another kind, such as stores, and the tendency

is to regard it in a much more familiar manner, if not to ignore it altogether. Immediately the entry is made in the cash book and the expenditure analysis posted, the transactions is considered closed. But from the financial point of view, control is just as necessary for the correct utilisation of the stores as it is for actual cash, and exactly the same rules, so carefully observed in the care of cash, should apply. The accounting records should place definite responsibility for the use of all supplies and readily consumable articles, and should provide the data necessary to allow of the consumption by the different units of the organisation to be obtained and compared. For this to be done, an efficient system of stores accounts is essential. It should form an integral part of the accounting system, and should be so framed as to afford complete touch with the materials from their receipt into the Hospital until their issue for consumption. Stores are nothing more or less than cash in another form—a change of assets—and the expenditure of cash in the purchase of stores merely transfers the need for control from cash to stores.

The cost of the material consumed, and not the cost of purchase, provides the debits to the accounts. Obviously materials should be charged in the accounts of the period in which they are consumed, and the balance in hand treated as an asset and included in the balance sheet.

CAPITAL ASSETS.

It has been said that it is not necessary for Hospitals to shew capital assets in the form of property and equipment in their balance sheets on the ground that the main purpose of a balance sheet is not to shew solvency but to shew accomplishment, and that the main purpose of a balance sheet shewing capital assets is to indicate that the concern is able either immediately or ultimately to pay its way. A little thought, however, will shew that it is desirable that detailed capital accounts should be shewn. The purpose of a balance sheet is not merely to shew solvency, but quite as much accountability, and a Hospital is responsible not only for providing results in the way of service, but for shewing that for everything entrusted to it, it has something of value. Further, in order to shew whether the amount of capital invested in Hospital property is out of proportion to the services rendered, it should indicate not only the total amount of such property, but also the sub-divisions of that investment among the various departments.

It has happened often that a Hospital has suffered high working costs because it has been inadequately supplied with facilities. It has been obliged to pay wages for work done by hand which might more economically have been done by machinery. On the other hand, a Hospital may have enjoyed low working costs because work has been done in large part by expensive equipment necessitating little hand labour. The adequacy or otherwise of equipment is a most important factor, and one which has a considerable bearing on the cost per bed as at present calculated.

For these reasons therefore it is most desirable that Hospitals should maintain complete balance sheets indicating what they have to shew for all property entrusted to them, what they have invested in interest bearing securities, and what they have invested in various types of equipment.

There are intelligent people who know of the needs of Hospitals, and it is suggested that the publication of a *full balance sheet* might conceivably lead to the raising of more adequate funds because of the obvious discrepancy between available capital and equipment needed for the work undertaken. The overdraft theory in connection with the raising of funds is now proved to be unsound.

EFFICIENCY OF EXPENDITURE.

The most difficult, and yet the most important, task of Hospital administration is the shewing of efficiency of expenditure. If the accounting system provides for a departmental system of classification of expenditure and a classification within each department by subjects, it is possible to obtain expenditure by activities. Unit costs may then be calculated for each. The limitations of such costs as a final index of efficiency are not lost sight of, but they serve a valuable purpose in shewing trends and as tentative standards by which the efficiency of activities may be judged. An increase in expenditure is not in itself a sign of poor efficiency or lack of economy, but when expenditures are reduced to units reliable comparisons may be made, and fluctuations inquired into, not annually, but continuously, month by month.

It is important to observe that efficient administration is not the science of doing without one's purpose, but the science of carrying out one's purpose without spending more than is absolutely necessary or running the Hospital into debt in so doing. Administration is not concerned with saving money as such, nor with expenses as such, but it is vitally concerned with the problem of gaining and sustaining the proper relationship between service rendered and cost of service ; or, in other words, cutting out all expenditure which does not contribute in adequate proportion to the eventuality of a fair return in the way of service. Every cost is purely relative and must not be considered out of its setting.

Economy obtained by means of accounts such as these is an entirely different thing from the so-called economy that one gets by using what is called the "broad axe." It is easy to reduce expenditure by cutting down departments or stopping work. Nothing is easier, but no value is obtained from the money saved in this way, whereas, if money is saved by the administration in the systematic cutting down of costs, the results are retained but the money is not spent.

The final test of the value of a system of accounts for Hospitals lies in its success in multiplying the power and increasing the effectiveness of the administration. Viewed thus, it will be seen that accounting is a vital factor in Hospital administration, and it should be developed along the lines of administrative procedure.

ECONOMY IN DRUGS AND DRESSINGS.

BY

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It is a platitude that few are so economical with the goods of others as with their own. Add to this the fact that few of those who prescribe the drugs and dressings used in hospital practice have any clear idea of their cost and there is ample reason for considerable waste of the money which voluntary hospitals gather with such pains from the benevolent public. My own interest in the economy of expenditure of hospital materials was first stimulated by the general need for saving which arose during the war, when, in common with the commanding officers of other military hospitals, I set to work to cut down all unnecessary expenditure of hospital materials. I quickly realised that to instil economy in the use of other peoples' goods into the habits of my subordinates was a much more difficult task than I had anticipated. Appeals to reason and to patriotic sentiment failed to oust the general feeling that waste of material paid for by other people was of no consequence, and it was only by constant watchfulness that waste of the kind which any reasonable person would characterise as idiotic was eliminated. Other commanding officers must have experienced the same difficulties judging by the comparison of costs in different military hospitals, which was periodically circulated by headquarters. Such an experience was a good preparation for the directorship of the V.D. Department at St. Thomas's Hospital, for which it was clear that the L.C.C. grant, though large, would leave no margin for waste after payment of adequate salaries and wages and costs of essentials.

Soon after taking over this department I noticed that for every patient suffering from a certain disease a certain mixture was prescribed automatically. I knew that my colleagues would agree that most of the patients for whom this particular mixture was prescribed, would get well just as quickly without it, and would admit that their main reason for the prescription was a fear that the patients would think they were not being properly looked after if they received nothing to swallow. I had no objection to the prescription of what was in most cases a *placebo*, so long as it did not make too big an inroad into the grant for my department. I strongly suspected, however, that this particular mixture would prove pretty expensive when repeated the many thousands of times which were likely from the turnover of my department, and a consultation with the chief pharmaceutist of St. Thomas's Hospital, Mr. Jennings, confirmed my suspicions, the price of the mixture proving to be over eightpence for the usual supply given to a patient. With very little trouble we worked out a prescription with the same therapeutic properties at a quarter the price, and I then had a little talk with my assistants on the subject. I said, first, that the hospital received such and such a grant for my department, so that the cost of any waste would be borne by the hospital, not by some public authority with a bottomless purse. That, of course, a patient must have what he or she really needed, but that, as they knew, many patients required no medicine, while for most others the cheaper prescription which the pharmaceutist and I had evolved, would work just as well as the more expensive which was then being prescribed as routine. My colleagues accepted my suggestions in the spirit I had hoped for, and this was the beginning of numerous little economies which have made this V.D. Treatment Centre the cheapest in the matter of drugs (other than arsenobenzol) and dressings of all such centres in the country. For the patient who won't be happy till he gets a bottle of medicine though he needs nothing, Mr. Jennings suggested two mixtures which cost from one-eighth to a fourteenth the price of our first essay in economy.

The expenditure of rubber gloves in a venereal diseases department is naturally heavy, as the workers in it must wear gloves for their own protection against accidental infection. I suggested that some reduction might be effected by repairing small tears. At first it was thought that repaired gloves would not prove to be safe, but, without further urging on my part, Sister Hutton, who is in charge of the nursing in the section for the treatment of females, took up the suggestion with such good effect that in 1921, when the whole department was working on a daily 8 a.m. to 10 p.m. service, and the attendances were 113,341 the expenditure of gloves was 452 pairs, as contrasted with 1920 when the expenditure of gloves was 611 pairs, though for most of the year only the section for males was open all day and the attendances were over 37,000 less. In the following year, 1922, only 442 pairs were used, though the attendances were 149,682.

Large numbers of wool and gauze swabs are used in the department, particularly for application to the bend of the elbow after vene-puncture in the administration of arseno-benzol preparations. The size of each swab appeared to be rather larger than necessary and the amount of wool in each was reduced in 1921 to about two-thirds. It is impossible to state the effect in the amount of wool expended in swabs, as the figures are not separable from the total expenditure on this and other accounts, including ordinary dressings and supplies of wool to the laboratory, but the expenditure of wool in 1922 was ten pounds less (442 lbs.) than in 1921, though the attendances in 1922 were 37,000 more than in 1921.

The result of these economies in drugs and dressings, each of them small enough in itself, is that the cost of drugs and dressings for the past two years has been 1·17 and 1·25 pence respectively per attendance, or totals of £726 to £654. It may be added that, under the admirable system of accounting at St. Thomas's Hospital, it is possible to arrive at a very close figure of the cost of each section of the hospital. All material for each department is supplied only on requisitions, which are priced and the amount debited against the department. Such a system is, I think, a great incentive to economy since the inevitable comparison stimulates competition between the different departments to reduce their costs.

As the special medical officer for venereal diseases in the Ministry of Health, I have the opportunity of comparing this cost with that of the same item in other centres in the country and can say with confidence that, if the cost of drugs (other than arsenobenzol) and dressings in my department were up to the average for all treatment centres, it would be not less than £3,000 per annum. Lest readers may think that I might have been employed in more useful work than worrying over pettifogging economies, I may add that the total time I have spent over this matter in my own department has been well under four hours in the four and a half years of my charge of it. The economies have resulted simply from the thought that, with such a huge number of attendances as ours, small recurring wastes would involve the hospital in very large expenditure.

The experience has proved useful in my work for the Ministry of Health. When the demand for national economy resulted in the recommendations of the Geddes Committee, I feared that the stoppage of all additional expenditure on the V.D. scheme would be the ruin of my hopes of re-organising many treatment centres on efficient lines. I set to work, however, to discover money for such reorganisation as I might think necessary, by pointing out where money was being wasted, and have found a very profitable field in drugs and dressings. In the course of my investigation of the accounts for services under the V.D. scheme which hospitals have presented, and in the numerous interviews which the enquiry has necessitated, I have rarely found that medical and surgical officers have given a thought to the cost of drugs and dressings. Often I have met with surprise that what was considered to be such a trifling matter should be thought worthy of my attention, but I have pointed out to some medical officers that, if the drugs and dressings bill in my own department were on the same scale as theirs, it would amount to over £8,000 instead of an actual £726 or less. To cite a few examples: A hospital at which a small centre had been established had contracted to supply the drugs and dressings for £109 a year. The size of the centre can be gauged from the fact that this small sum worked out at 4d. per attendance. One year the hospital applied for a further payment of £260, by which sum they had exceeded their contract, raising the cost of drugs (other than arseno-benzol) and dressings to 1s. 2d. per attendance. Enquiry into the details elicited that no less than £117 a year was being spent on bandages. I made a guess at the cause of expenditure and offered the opinion that it is not usually necessary to bandage a patient's arm after an intravenous injection. This elicited the retort that it would be dangerous to allow a patient's shirt to come into contact

with such a wound. I found later that the vene-puncture wound was dressed with at least six layers of cyanide gauze, followed by a large piece of wool and several turns of bandage. Yet no dressing was applied to the much deeper wound in the much less cleanly area of the buttock which was made by way of giving an intramuscular injection to the same patient. In another centre it was discovered, after the failure of the hospital to find any wastage, that in a stock mixture of iodide of potassium was another ingredient with which the iodide was really incompatible, the result being a very inelegant mixture. The cost of the effective ingredient, the iodide of potassium, was sixpence, that of the incompatibility was one shilling and fourpence. The prescription had been in the hospital's pharmacopeia for many years, and the medical officer who had prescribed Mist. Pot. Iodid. to the extent of several thousands of bottles, learnt of the presence of the incompatible and costly ingredient for the first time at a conference between the hospital and the health authority, at which I assisted. In another hospital with a comparatively small turnover and a high drug bill, I found that the expenditure on a proprietary medicated pessary was £105 a year, or 8d. per attendance, yet the medical officer was quite ignorant of the cost, and could not name any special advantage of this particular pessary over a substitute I suggested costing a tenth the amount.

It is unnecessary to cite any of the numerous further examples which are available to show that few medical and surgical officers realise the price of the drugs and dressings which they prescribe and often use so lavishly and that, if they did, a little appeal on the part of the hospitals which they serve would cause them to effect such economies as would be equivalent to very substantial donations to the hospitals' funds.

CONTRIBUTORY SCHEMES.

BY

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In the spacious days before the war, hospital administration all over the country presented no great difficulty, and was seldom a source of financial anxiety. The necessary funds were obtained, as they always had been obtained, partly from subscriptions of people in the neighbourhood, and partly from the income arising from invested funds, which were mostly the proceeds of legacies left by subscribers who wished to ensure that their subscriptions would not cease at their death. There was no question of charity, using the word in its less pleasant sense—well-to-do people regarded the support of their local hospital in the interests of their poorer neighbours as a pleasure as well as a duty—and whenever any stringency did occur or if some improvement or addition became necessary, the wherewithal was generally obtainable by means of an entertainment or a special whip-up. It is true that the cost of administration tended to increase, but the rise was slow and regular, and taking one institution with another, was generally well covered by the increasing dividends from accumulating legacies.

Hospitals were managed by representatives of subscribers and donors of funds, neither patients nor anyone else having any voice in their control.

In the light of our present knowledge, management was seldom economical and very frequently extravagant, which, with plenty of money, old-fashioned methods, and governing bodies in many cases in the hands of the staffs, was not surprising.

During the war, or at any rate during its earlier years, many hospitals continued to be prosperous or to have the appearance of prosperity, and various causes contributed to postpone the hour when a shortness of money would be felt. Owing to a number of potential patients being on service, many beds were either empty and therefore costing nothing or, as was the case in many instances, occupied by wounded soldiers for whom the country was paying fairly handsomely.

There was practically no outlay on building as circumstances prevented any new work, and even the most necessary repairs and renovations had to be put off, partly in the hope that prices would fall, and partly because labour and materials were difficult or impossible to obtain.

But, after the war, which in hospital administration, as in many other directions, was the gulf dividing the old order from the new, every hospital Committee was faced with difficulties which in very many cases were the more acute in that they had not been foreseen, and, as far as might be, provided for. In every direction was the necessity for spending money. First, and most pressing, was the accumulation of repairs. It was not possible to put these off any longer, and in some cases the cost had to be met by the sale of part of the invested funds. Secondly, came the postponed schemes for extensions—Nurses' Homes, X-ray rooms, remodelled kitchens, and a score of others—which had been on the stocks for years. Towards these the Joint War Committee of the British Red Cross Society and the Order of St. John came to the assistance of hospitals, by grants from its surplus funds to a total of about £1,360,000. A grant was never given for more than one half the cost of a scheme, the hospital having to find the balance. Inasmuch as the cost of all building had at least doubled as compared with before the War, this meant that a hospital which had a capital fund for a particular scheme on a pre-war basis was able to carry it out, which otherwise it could not have done at the enhanced prices, but hospitals without such funds were in very serious straits. Thirdly, there was the most important item of expenditure,

viz., the ordinary maintenance of a hospital. Boards of Governors were confronted with the fact that the cost of living had risen by nearly 100 per cent., and shewed no sign of reduction: but this was only part of the trouble, for it very soon became apparent that even if prices had remained at, or returned to the pre-war standard, the cost of hospital administration would be still for the future much greater than it had been in the past. To this various causes contributed, but, broadly speaking, they fall under two heads, first, the increase of Staff required by the shorter hours being worked, and secondly, the hundred and one requirements which were the result of the enormous advance in medical, surgical and electrical scientific knowledge during and following the war.

The fact that the cost of administration had doubled need not have alarmed Hospital Boards if the income had increased correspondingly, but this was very far from being the case. Dividends from funds invested before the war remained at the old figure, with half its old purchasing power, and the subscriptions of the Old Rich, who had become the New Poor, tended to decrease very considerably.

In the hard school of adversity Hospital Boards had learned and begun to practise economy in food, in drugs and dressings, in household requisites and in administration generally. Articles such as soap, for instance, which previously had been bought by tender, taking the lowest price, were being purchased on analysis so that water was no longer being paid for at the price of soap. One of the conditions of the Joint War Committee in making any grant of £1,000 and upwards was that the hospital accepting the grant must agree to keep and render its accounts in a standard form, and this effort to bring about a measure of co-ordination has already been productive of good.

But after every possible economy had been practised hospital administrators were faced with an inevitable hopeless deficit on the ordinary working of the institutions. A small section of the public took advantage of these difficulties to clamour for the voluntary hospitals to be replaced by rate-provided institutions, and it began almost to look as if this overwhelming calamity might come about.

The only alternative to this was to increase the income of hospitals—and the only possible source from which this could be derived was the class from which hospital patients were drawn. Many of them individually are quite without the means of paying anything at all, but collectively they are wealthy and when really put to it, hospitals and those interested in them found that it only required organisation to tap this spring of wealth and so to save their hospitals.

A system of Workmen's Organised Contributions as a regular source of income, though novel to most people, is not really new. For instance, it has been practised with great success by the Chesterfield Hospital for at least twenty years. This scheme had been so well thought out that to this day it remains unchanged and might still be taken as a model of what such schemes should be, and in several other localities, *e.g.*, Gloucester, large firms have for many years collected funds for their Hospital by regular deductions from wages.

But these were the exceptions. It is only in the last three or four years that the system has become really widespread; it is now extending so rapidly that beyond doubt it will very shortly be universal.

An examination of the schemes of various hospitals is very interesting; for while in essence a contributory scheme would not seem to admit of much variety, it is a fact that there are scarcely two which are precisely alike.

Most hospitals nowadays while admitting free any patient who cannot afford to pay, do quite definitely expect to receive something from those whose circumstances permit payment. Such payments are nearly always for maintenance only, treatment being given free—indeed many hospitals are precluded by the terms of their Trust Deeds from making any charge for treatment, and where there is no such actual embargo, to make a charge would mean possible difficulty with the Honorary Medical Staff, and in the opinion of many people would be in conflict with the basic principle of hospitals maintained by Voluntary Subscriptions, which is to provide free treatment.

Maintenance—the actual out-of-pocket expenses incurred on account of patients for food, laundry, etc.—is quite another matter; a person while in hospital is saving the cost of his maintenance at home so that it is reasonable and equitable that a hospital should expect payment for bare maintenance, and this is customary now, it being clearly understood that where such payment would really be a hardship it is not exacted. This charge for maintenance is an important factor in the organisation of a contributory scheme—indeed it may be said to have made such schemes feasible, though theoretically, and in some cases actually, they can be managed without it.

A workman who pays a fixed sum each week to his hospital expects, and is entitled to, a quid pro quo, and he obtains this, under most schemes, by being free of the obligation to pay for his maintenance when in hospital. His subscription, in fact, amounts to an insurance premium, the benefits resulting from which vary according to the scheme.

One of the objections that used to be made to the system of contributory schemes was that payments by patients would diminish, but nothing could be more desirable than that payment by patients should cease altogether if this were brought about by every potential patient being a contributor under an organised contributory scheme. It is safe to say that any hospital where this might be the case, would be free from any financial anxiety.

The bare outlines of a simple Contributory Scheme may be set down as follows :—

1. Workmen to pay, by deduction from wages, a regular weekly sum to their local hospital, (say) 2d. if a single man, 3d. if a married man. Self employers to pay the same either by a card or by an annual lump sum.

2. All contributors to be entitled to free maintenance in hospital, for themselves and wives and families.

3. Representatives of the contributors to serve on the Hospital Board, their number being proportionate to the income raised.

4. The work of organisation to be carried out either by the hospital, or by a separate organisation.

5. Workmen, employers and trade union organisations to co-operate.

6. Contributions to be entirely at the disposal of the hospital or hospitals concerned.

7. Cost of running the scheme should be low, *e.g.*, not more than 2½ per cent.

8. Politics and discussions on controversial subjects, such as anti-Vaccination, to be rigidly banned.

Such a scheme can be varied, reduced or added to to any extent, to suit existing circumstances. Some schemes provide separately for or include convalescent treatment and dental treatment, some actually guarantee the various benefits, but mostly this is not the case. Where a guarantee is given, the scheme becomes an insurance scheme pure and simple.

The following details from four hospitals may be taken as typical of various kinds of schemes—simple and more elaborate—in different parts of the country.

1. *CHESTERFIELD ROYAL HOSPITAL.*

Worked by the Hospital. Contributions 2½d. weekly, obtained by deductions from wages. Workpeople have twelve Representatives on Board of Management. Contributions provide 60 per cent. of the income of the hospital. The scheme is the oldest in the country, having worked and worked well for twenty years. This may be regarded as typical of the ordinary Contributory Scheme, a great many others being very similar.

2. *GLASGOW.*

Worked by a Committee representing the seven large hospitals and the District Councils in and near Glasgow. Contributions varying from 1d. a week from wages under 30/-, to 6d. a week from wages of £7 a week upwards, are deducted from wages. Firms and employees societies contributing £5 5s. have the right to send delegates to the Court of Contributors which body nominates representatives to sit on the Board of Management.

The proceeds are given wholly to the Hospital and spent on maintenance only.

3. *OXFORD.*

Worked by the Radcliffe Infirmary through group and village Committees, there being 4,000 voluntary secretaries and collectors. Subscriptions are obtained by collectors as follows: 2d. a week for men, 2d. for wives and 1d. for non-wage earning children. Nine seats on the hospital Committee of 28 are being given to Contributors. There is a pooling arrangement between the Radcliffe Infirmary and the Cottage Hospitals.

4. *WINCHESTER.*

Worked by the Royal Hampshire Hospital. Contributions obtained partly by deduction from wages, partly by collectors. This is specifically an Insurance scheme, the rates being 2d. a week for each adult, or 4d. for a man, wife and children under 14. Salaried persons of moderate means pay 10s. 6d. each per annum and 5s. per child under 16. The guaranteed benefits are, free in-patient and out-patient treatment, free maintenance in any hospital in Great Britain and free maintenance in any Convalescent Home, but Maternity benefit is not included. Contributors are represented on the Board of Management. All contributions are paid to the Hospital.

The organisation of schemes such as these all over the country is ushering in an era of solid prosperity in our Voluntary hospitals. The fact that patients can and do pay for their maintenance by their contributions makes them independent and free from any possible feeling that they are, while in hospital, the recipients of charity, and by giving them, as a right, representation on the Board of Management of their hospital, contributors take their share in its control, and learn to understand the difficulties that hospital administrators are constantly confronted with. It is beyond all doubt that as a result of these far reaching changes, hospitals are to-day, as compared with a few years ago, more prosperous, more alive and more efficient; and the Governors of any hospital which has no Contributory scheme in operation will be wise if they initiate one without delay, and push it with all the power at their command.